

## California State Journal of Medicine.

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## EDITORIAL NOTES

### NOTICE!

### Forty-Fourth Annual Meeting.

SANTA BARBARA, HOTEL POTTER,  
APRIL 14, 15 AND 16, 1914.

**RAILROAD RATES.** The customary railroad rate of one and one-third fare, provided 50 or more are in attendance, will prevail. When you buy your ticket to go to Santa Barbara, pay the full fare and get a receipt-certificate. When you get to Santa Barbara, present this to the Secretary to be signed and then when you get your return ticket, hand this receipt to the agent and he will give you a return ticket for one-third the full fare. Do not fail to get the receipt-certificate or to have it signed by the Secretary, for if you do, you have no redress.

**HOTEL RATES.** The rates this year are on the European plan and do not include meals.

Room, without bath, one person, \$1.00  
Room, without bath, two persons, 1.50  
Room with bath, one person, 2.00  
Room with bath, two persons, 3.00

Those who desire may be accommodated on the American plan, in which case add \$2.50 per day per person to the above rates.

**THE PROGRAM** this year promises to be excellent and should call out a large attendance. Every delegate should make it his first business to attend this session as matters of the utmost importance will come up for consideration. Questions have

arisen in which every member of the society is vitally interested and the delegates, who represent large numbers of our members who cannot attend, should be sure to be present, even if at a personal sacrifice.

Secretaries of county units should make it their special duty to attend this meeting so that they may be in a position to explain to their members just what was done and why. County Secretaries can do this much more effectually by talking directly to their members than it can be accomplished in any other way.

### WHY NOT SAVE THE MONEY?

One of our advertisers is good enough to give us information in regard to specific instances wherein his advertising in your JOURNAL does or does not pay. A customer came to his store and noticing a certain article remarked that he did not know they carried that; he had just bought one from an eastern house and had had to pay the same price, plus the express charges of \$3.40. And that very article had been advertised in your JOURNAL. The local dealer would have saved that member at least \$3.40. Does it pay to look through the advertising pages? It would have paid that one doctor on that one purchase, \$3.40; how much more he has thus foolishly spent it is impossible to say. Another definite instance where a member bought from an eastern house an article advertised in your JOURNAL by a local dealer, is one in which the article cost the purchaser 25% more than he could have bought it for right here at home. It is safe to say that members could save much more than the amount of their annual dues if they would look through the advertising pages of their JOURNAL and purchase goods from their own advertisers. "It pays to advertise" is very true; it is also and equally true that "It pays to read advertisements"!

### SUITS FOR DAMAGES AND THEIR DEFENSE.

Some of our members who have joined in the last year or so do not understand that the State Society has a legal department of the very best and that it defends its members, without cost to them, other than their regular dues and assessments, in all such actions. Membership in the State Society, because of this one feature alone, is now one of the most valuable assets that a practicing physician can have. The suits which we have defended, all of them successfully, in 1913, would have cost the individual physicians sued a great many thousands of dollars—and they would not all of them have been won. Our legal department is so well up in this work and our lawyers are of such high standing that in many cases where the member has also had insurance in some company, he has requested our attorneys to take charge of his case. The rules covering this work, formulated by the Council, are very simple and it may not be untimely to remind our members of them.

First of all, a physician must at all times be a member in good standing of his county medical

society. No one will be defended who was not a member at the time he treated the patient for the alleged malpractice and also at the time when the suit is brought; that means he must be continuously a member. All memberships terminate on December 31st, but all who were members on that date are carried as members till March 1st, at which time they are automatically dropped as from January 1st and when they pay up and their names and the amount of the assessment for them are sent in by the secretary of the county unit, then they are placed on the roll as from the date when the name and the money was received in the office of the State Society. They have lost their protection between the first of January of that year and the date when they are again put on the roll of members. Therefore it is important to see that your dues are paid promptly in January, when they are due. When any threat is made against a member or any claim for repayment of money or anything of that sort, it should be reported at once to the Secretary of the Society, Dr. Philip Mills Jones, Butler Building, San Francisco. When this is done it enables us to head off a good many suits that otherwise might be brought. When a suit is filed and the papers are served on a member, he must send them, or an exact copy, to the Secretary within 48 hours. We are not responsible, financially, for any unauthorized consultations with local lawyers. When our chief counsel cannot attend to cases personally, he arranges with a local attorney, after consultation with the defendant. Never answer any threatening letters from patients or lawyers; send them immediately to the secretary; be sure that your dues are always paid up; if you are served with papers in a suit, send them immediately to the secretary.

Could any rules be simpler? Suits are increasing rather than decreasing; there seems to be a craze to "sue the doctor"; are you protected? You do not and cannot know what day some disgruntled patient may sue you. It is much wiser to pay the few dollars a year your dues cost you than many hundreds or thousands of dollars it would cost you to defend a suit. Medical defense by the State Society is real defense; it defends.

#### A NEW MEDICAL (?) ORGAN FOR "SLAMMING."

Apparently there were not in existence enough so-called medical (?) journals living on fraudulent and deceitful advertising and so desirous of slamming the American Medical Association; a new publication has been started, but whether it will be parasitical and thrive on the nostrums is not yet certain; it is young, very young, and its circulation is bound to be small, very small. It is the *Journal of the American Medical Editors' Association*, that highly upright and cleanly organization of which mention has been made before, in the pages of the *JOURNAL*. Vol. I, No. 2, is the issue under present observation and it contains three separate items that are intended to be deliberate slams at the Association. Two of them

relate to the row that Lydston has tried for years, very ineffectually, to start in the Association. He tried to get the public prosecutor in Chicago to take legal action against the Association to have its present form of organization dissolved. The public prosecutor would not do this so action was taken against him to compel him to do it; he was sustained and the case then taken on appeal; the appellate court reversed the lower court and ordered the case against the public prosecutor tried. This decision of the appellate court has been appealed to the supreme court of Illinois by the public prosecutor. The case has not come near the Association at all; if the supreme court should decide that the public prosecutor must proceed against the Association, why then there would be a suit against the Association. As some of the best lawyers in Chicago incorporated the Association, and then studied the matter out very carefully and reincorporated under the present form of organization, it does not seem likely that a suit will ever be won dissolving the present form of organization. But if such should be the case, what does it mean? Merely that the Association will have to reform in some other manner and one conforming to the construction of the laws that the courts may put upon them. And this is the terrible thing that has happened to the Association—according to its not-too-clean-handed enemies! We wish this new medical (?) journal as long a life and as successful a career as its honorable and upright intentions and its honesty of policy may entitle it to receive.

#### A SUGGESTION FOR HELP.

The Santa Barbara County Medical Society publishes a printed announcement and program of meetings which is sent out to the members a week or ten days in advance. This is an excellent idea in itself, but it was not the particular thing in mind. A few months ago the Secretary very thoughtfully printed in this announcement, a list of laboratories and biological depots advertising in the *STATE JOURNAL*. Will not every county society that issues a bulletin or prints an announcement, from time to time give a list of a number of different advertisers in some line of activity or another, which advertise in the *JOURNAL*? Will the editors of those bulletins be good enough to call attention to the fact that members may very often save money by buying what they need from our advertisers rather than by sending to some eastern house for the article? Two instances of an actual saving of this sort—or rather, a saving that was not!—are referred to in another editorial note in this issue. Nearly everything that you may want to purchase can be secured from some advertiser in your *JOURNAL* and by trading with him you are returning the compliment he has paid to you by placing an advertisement in your *JOURNAL*. We wish to thank Dr. Barry and the Santa Barbara County Medical Society for their courtesy and their good sense and it is sincerely to be hoped that other societies will follow the same good example.

### THE COSTUME OF "THE COLLEGE."

In several comments adverse to the new American College of Surgeons we find the institution objected to on the ground of its exotic character. There is an imputation of a departure from American ways; the sober-minded among the critics discern invidious and undemocratic distinctions, which the facetious exaggerate into the establishment among surgeons of a haughty peerage, possessed of undue privileges. That the founders of "the College" do not intend to cultivate Jeffersonian simplicity is true, as appears from the information which has reached us regarding the official costume of the Fellows: this is indeed exotic and calculated to confirm apprehensions of aristocratic academic pretensions, which we would be at some pains to allay.

The price of the gown awakens no suspicion of the splendor it will purchase. It is \$11.90. The amount is probably not the result of a mere caprice of economics. Its rather sudden halt before the dozen suggests a psychological influence. We fancy we see a propensity to prodigality checked by prudence: magnificence there must be, though not at any price, and magnificence there will be. For we read: "Body of Gown, navy-blue mohair. A scarlet velvet facing five inches wide extends around the neck and down each side of the front. The Cap is of same material as Gown with scarlet tassel."

Verily a dainty creation, judging from this description. But the accompanying illustration shows us the familiar cut of the garb of an Oxonian. No sense of incongruity here in translating the traditional vestment of Oxford, which "whispers from its towers the enchantments of the Middle Ages" to where the characteristic note is the last squeal of the butchered pig resounding from the shambles.

It may be urged that an Oxford gown and cap, having been adopted in so many scholastic establishments of America, should not be considered exotic; to which we can only return that the term is applied rather with regard to American principles than to American practices. And, by the way, if the American College of Surgeons is to look to other academic institutions in this country for its models we may yet be apprised of its having adopted a college yell,—for which an imitation of the vociferation of the afore-mentioned victim of the stockyards may be recommended.

But back to the dazzling robe! There are attributions critics who deny that scholarly dignity is enhanced by gaudy garments. They must be blind indeed to the advantages of pageantry; and may we not infer that the navy-blue and the scarlet velvet are to serve the purposes of pomp and ceremony? Is there not further foundation for the assumption that gorgeous spectacles come within the scope of the College in the article of its by-laws which states that the object is to "elevate the standard of Surgery"? Unread in the Philosophy of Clothes must he be who would cavil at the costume of "the College" and its variegation. Let such an one turn to his Sartor Resartus and there learn with what a shudder Professor Teufelsdröckh pictured to himself a solemn festival at Court spoiled

by the starting of the buttons and the evaporation of solid wool, "the Clothes flying off the whole dramatic corps," leaving common clay where had stood before Majesty and resplendent dignitaries: with a like shock would he contemplate an assemblage of the Fellows, where, just at the moment when perhaps seven thousand degrees are being conferred, the Standard of Surgery drops from its elevation, the tassels cease their waving, the solid mohair evaporates, the velvet slips from the several necks and down each side of the several fronts, the scarlet and the navy-blue fade away, and the whole company stand revealed as ordinary doctors who incise and suture and puncture for a living.

### "SOCIAL FERMENT."

Dr. Henry B. Favill, of Chicago, the Chairman of the Council on Health and Public Instruction of the American Medical Association, in an address before the last meeting of the Mississippi Valley Medical Association, opens his subject, "Child Culture the Function of Organized Medicine," with some paragraphs that are well worth repeating. Indeed the whole address is well worth careful reading and we only regret that it is too long for us to give it space in the JOURNAL; a copy can be had, however, by sending a request for it to the Secretary, Dr. Fred. R. Green, 535 North Dearborn St., Chicago, Ills. For something over two years your JOURNAL has been calling attention to the widespread condition of unrest that is to be found all over the country and in all walks of life and to many instances in which it has exhibited itself within the medical profession or without it, but affecting it materially. Of this same condition Dr. Favill says:

"In regarding the field of human thought one is impressed with the intense activity of what may without exaggeration be called social ferment. In every direction which one may look there is evidence of unprecedented stir. Nothing goes in its familiar lines, nothing maintains its accustomed pace. The world is agitated. This is not confined to human action; it is fully as marked in the realm of abstract conception, and through it all penetrates a spirit of intellectual adventure, which beyond doubt is the influence which is ultimately to bring some order out of very obvious chaos. To this activity we react variously. The conservative is disturbed, perplexed and often pained by the radical and iconoclastic temper of the time. The radical is inspired, stimulated and often intoxicated by the wonderful kaleidoscopic readjustments which ensue on agitation of the foundations. Between abide the mass of people, partly thinking, partly dreaming, partly stolidly accepting the dictate of the day. Superficially, the outlook offers opportunity for captious criticism. In the tearing asunder of the social fabric, dignity of life, stability of equilibrium and quality of taste seem to be disregarded. In the desire to see the wheels go round, the delicate mechanism is threatened. In the passion for ultimate knowledge, the beauty of the flower is destroyed."



## WHERE DOES THE DOCTOR COME IN?

To the Editor of the STATE JOURNAL:

Dear Sir: At a meeting of the San Francisco County Medical Society, held Jan. 6, 1914, the plans of the Industrial Accident Board of the State of California, were unfolded to the medical profession.

It is not my purpose to question the economics of this movement, but one point is not clear to me. It was stated that the cost of this insurance falls on the "ultimate consumer." Every employer raises the price of his commodity and the employees constituting the larger proportion of the population pay the larger part of the tax. Does it really work out that way? Wages in this state are higher than in any community and the manufacturers are pretty well handicapped now in trying to compete with other communities and countries. Can they raise the price of their commodities?

Again, add together the employees of the railroads, street-car companies, telephone, gas and electric corporations, the sum would approximate if not exceed one-half the employees of the state. Do you believe for one instant that the various commissions appointed for the sole purpose of reducing the rates of these corporations will allow a raise? However, we are mainly interested in the effect of this measure on the medical profession. As I listened to the honeyed phrases of what this board is going to do for the medical profession, they sounded very familiar. I am coming to the belief in reincarnation. Methinks that thousands of years ago in a previous incarnation I heard those same phrases on the banks of the Euphrates. "Just compensation" forsooth! Just the compensation that the barnyard fowl of the story received, in just the same segment of the vertebral column and with just the same carpenter's implement. You may recall the days of the San Francisco fire; laborers received three dollars a day for eight hours' work, six days a week; the medical man received \$100.00 a month 24 hours a day and seven days a week. Are the medical men employed by the Board paid by piecework? Nay, nay, so much a month, no matter how much they may be obliged to do.

How about the insurance company? Have you heard? Ten per cent. of the premium collected for which the doctor not alone attends the patient, furnishes medicines and dressings, but pays the hospital expenses as well, should a stay in a hospital be required. What happens to the man who still has faith in his regular medical attendant? He and his doctor are watched by a State Inspector (let us hope he has some idea of surgery) and the moment said inspector feels that he can do the job better, the patient is carted, noliens volens, to a hospital. And what hospital? The state will contract with some institution to take care of its dependents. Will it send them to one of the so-called contract hospitals? Oh no, they are under the ban of the medical societies. A contract will be made with the university hospitals and I am wondering what the labor organizations will say when they learn that their members have become clinical material.

There is, moreover, a far greater aspect to this movement. Kindly file the following statement somewhere for future reference! When the state legislature meets in January, 1917, the Accident Industrial Board, proud of its success and moved by the "progressive" spirit of the times, will introduce a bill extending its functions to include all sickness. Of course there must be a maximum wage limit and it will be fixed where the income tax begins, \$3000 a year. And where will poor robin be then?

The only hope for the medical man who is not in the employ either of the state or an insurance company, is lost. He is facing the problem his confreres have faced in Europe and his time for action is now. But if he applies to his county society, the one organized body to which he can appeal, what is the answer? Contract practice is not ethical.

The time has come and the need is urgent that every medical man must join his county society and see that immediate action is taken for the protection of himself and those dependent on him.

H. B. A. KUGELER.

## THE INDUSTRIAL COMPENSATION ACT.

The state law which went into effect January 1st and which provides for the care, treatment and compensation of an injured employee, touches our profession immediately and in many essential ways, for obviously, an injured person must be treated by a physician as soon as possible and thereafter attended by a doctor until he is well. Two quite interesting meetings were held, one in December in Oakland, the meeting of the Alameda County Medical Association, and the other in January, at the San Francisco County Medical Society; the former was addressed by Mr. Pillsbury, of the commission, and the latter by Mr. French, of the commission, and by Dr. Morton Gibbons who has been appointed the medical officer at the head of the insurance feature of the act. A number of points of great interest were brought out at these meetings. Under the law, the employer has the right to call or designate what physician shall treat the injured person; when the employer has insurance, this right is transferred to the insurance company. The patient has nothing to say about it. The commission has very wide powers to adjust difficulties and differences that may arise and it is admitted, unofficially, that possibly in some instances the patient may be permitted to have something to say in the matter of his physician. The commission state that the vast majority of accidents are trivial and that the employed and injured person is not kept from his work for more than two weeks; for this reason no compensation is allowed for that period of time and unlimited medical or surgical attendance may be provided. Arrangements have been made by many, and are being made by all the rest, of the insurance companies, with hospitals and with physicians to do this accident work at special rates. Naturally, the amount of these proposed rates is a question of great interest to all concerned. The commission states



that the amount to be paid physicians for their work should be commensurate with the income of the injured person; that the charge should be what he ordinarily would be charged by the doctor if he had to pay the bill himself and not have it paid by the employer or the insurance company; there seems a good deal of reason in that contention. Many of the companies—some sixteen or more, we believe—have formed a schedule of fees that seem to be very much too low except as applied to the very poorly paid, if we are to consider the matter as being measurable by the amount of wages or salary paid to the injured employee. Many physicians have been asked to sign a blank contract-form agreeing to accept these fees and to undertake to do the accident work for the company at these terms. The state insurance department has not taken this course of action and has not asked the physicians whom it has approached on the subject to sign any such contract; they intimate that the fees which their company (for the state has gone into the insurance business on the same general lines as any company and so may be referred to as such) will pay will be, in most cases, higher than those indicated by the other companies. It would not seem wise, therefore, for any of our members to sign contracts at the present time. It is not reasonable to expect a good surgeon to set a fractured arm or leg for \$12.50 and to treat the patient thereafter for \$1.00 per. Furthermore, there is nothing in the law to prevent the injured person from suing the doctor for alleged malpractice, if he chooses, though he may not sue the employer. It looks very much as though a good many such suits for damages against doctors would be brought as a result of this act, and as the State Society defends its members in these suits, it would seem to be very wise to consider whether the Society should accept for membership, or at least defend any suit against, a physician who contracts to do this work at these small fees.

#### OTHER PROBLEMS BROUGHT UP.

Furthermore, is it fair to divert the practice that would naturally go to the family physician, to some physician who has entered into these contracts? And what is to be the position of the doctor who is called in an emergency and first treats the patient? It might be serious if not fatal to keep an injured person waiting without treatment until the services of the particular physician of some particular insurance company could be secured. The commission has unofficially stated that the reasonable bill of a physician for his emergency work will undoubtedly be allowed. That is good for the state insurance company, but can the other companies be forced to take a similar line of action in dealing with the first-aid physician? The powers of the commission are large and it is believed that they can force the other companies to do so, but the point is uncertain. How is this act going to influence the contract-practice evil, already too vicious a one and growing? Will employers demand that their employees become members of some one of the hospital associations that furnish medical and surgical treatment (of its kind!) for one dollar a month, and not go to the expense of taking out

insurance? Will they demand that one seeking employment shall be thoroughly examined as to his physical fitness before giving him a job? Several large employers of labor have already instructed their employees that they must be examined and that no one not absolutely sound physically can be retained in their employ. Many a man is not quite sound physically but is well enough to do the work he is engaged upon, even though his unsoundness makes him a little more likely to be the subject of an accidental injury, trifling or otherwise. Just how this act is going to work out, it is of course impossible to say. Indeed there are many points upon which the commission is itself in doubt and which only the future can solve. There are some things, however, that we can accept as almost certain: this form of state indemnity and insurance has come to stay, in one form or another, and the best thing we can do is to try and mold it better and not endeavor to oppose it. It would also seem to be pretty clear that it will tend to increase the contract-practice evil and so it is essential for us to consider this in its relation to the State Society and membership therein.

#### INDUSTRIAL ACCIDENT LAW.

(Speech in part of Will J. French, Commissioner of the Industrial Accident Commission, delivered before the San Francisco County Medical Society on Tuesday evening, January 6, 1914.)

Mr. Chairman, Ladies and Gentlemen: Mr. A. J. Pillsbury, chairman of the Industrial Accident Commission, is, unfortunately, on the sick list this evening, and he has requested me to keep the appointment to discuss with the members of the San Francisco County Medical Society the new compensation law which became effective on the first day of this month.

The National Council for Industrial Safety estimates the number of killed and injured in the industries of the United States each year at 2,035,000. Just think what this means! Every hour 232 workmen killed or injured; every 15 minutes a workman killed; every 16 seconds a workman injured. These stupendous figures are corroborated by Doctor Frederick L. Hoffman, perhaps the leading statistician of the country, and W. J. Ghent, also an authority, believes they are conservative indeed.

No one can depict what this waste of human life and energy means, because no man's life can be accurately measured in terms of dollars and cents, and the loss to the Nation is so great that it is high time the best thought available was directed toward a solution of the loss. When it is believed by careful students that nearly half of these deaths and injuries could be prevented, the loss on the ledger of social efficiency is even more striking than a first glance at the figures might indicate.

#### BIRTH OF THE COMPENSATION MOVEMENT.

A few years ago a group of men and women investigated some of the causes of poverty in our industrial centers. It was found that industrial accidents and their consequences came third on the list, preceded by sickness and unemployment. The

next logical thing to do was to ascertain how other countries are combating this third cause. It was found that nearly every country of Europe has a compensation law of some sort, and that the same applies to the Australasian lands beneath the Southern Cross.

It would take too long to attempt to describe these laws. Suffice it to say that Germany, as usual in social legislation, has led the way down through the years, and that the people most backward in passing laws and endeavoring to stop the human waste live beneath the Stars and Stripes. But it has not taken long to arouse an intelligent interest, and to-day nearly thirty states either have compensation laws or are planning their adoption. The Federal Government is considering two bills designed to care for the dependents of the killed, as well as for the maimed, in the employ of Uncle Sam. One of these proposed laws will undoubtedly soon be engrossed on the statute book, and that will mean an advanced forward step and have a tendency to bring about a much-desired condition, namely, uniformity in the legislation adopted by the states.

#### THE ONE WORD THAT TELLS THE DIFFERENCE.

Frequently those of us who talk on this subject in public are asked what is the difference between liability and compensation. As you know, liability laws preceded compensation laws, and now the tendency is to depose liability and substitute therefor compensation. One word in the English language tells the story. That word is "negligence." Under the old system the injured worker had to prove his employer responsible in some way for the accident, either directly or indirectly. This might be accomplished directly because of unsafe surroundings, the breaking of machinery, or in other numerous ways there was a possibility of showing immediate connection. Indirectly the same result might be attained by reason of the carelessness of a fellow worker or the abolishment by law of the employers' defenses of "assumption of risk" or "contributory negligence."

#### LIABILITY CONDEMNED.

There isn't a man or woman who has given the least thought to the question before us who doesn't think that it is high time to install compensation. Liability represents the crude way. It is devoid of equity. Millions of dollars are paid out to the wrong men in the form of premiums for protection against lawsuits. And there ought to be no lawsuits. They are costly, represent delay, friction between employer and employee, and an uncertainty of outcome that handicaps both sides. There is no telling what a jury will do. Many times a heavy award has been given for a minor injury, and a small amount for a major injury. So acute has become the situation that unless a lawyer is able to make arrangements with an injured man, the latter will almost invariably accept a trifle to escape a vexatious condition and to provide food for those of his household. It must not be forgotten that in the great majority of industrial accidents it is impossible to prove negligence, even though it may exist, and absolutely no claim is then

possible except upon the generosity of the employer.

#### WHY COMPENSATION?

Because it is sane. Because the world experience points the way. Because it is the natural medium of transferring the cost from the shoulders of the widows and little children and the crippled to the industry, which is not only infinitely better able to stand the strain, but which should because bone and muscle is an element in production heretofore not taken into account, excepting in the very rare cases when success attended a suit in the courts under a liability law. Another good reason is that negligence is abolished, and all accidents are considered as incidental to business, unless employers are guilty of wrongful acts or the employees are injured by reason of intoxication or wilful misconduct. And still another excellent reason is that the millions paid by employers for protection in the courts will not be needed for that purpose and nearly all of the money will find its way into the pockets that need it most, and both sides will prefer this change. There are so many other reasons that time will prevent their recital.

#### THE ATTITUDE OF THE PEOPLE OF THE STATE.

That there is a pronounced opinion in California in favor of a change from employers' liability to workmen's compensation is evidenced by the vote on October 10, 1911, when proposed amendments to the State Constitution were submitted to the people. By a vote of 147,567 for, to 65,255 against (a majority of 82,312), this section was added to Article XX:

"The legislature may by appropriate legislation create and enforce a liability on the part of all employers to compensate their employees for any injury incurred by the said employees in the course of their employment irrespective of the fault of either party. The legislature may provide for the settlement of any disputes arising under the legislation contemplated by this section, by arbitration, or by an industrial accident board, by the courts, or by either, any or all of these agencies, anything in this constitution to the contrary notwithstanding."

#### THREE INTERESTING VIEWS.

In industry a broken piece of machinery is repaired, while an injured man is usually replaced. President Woodrow Wilson, in his latest book "A New Freedom," says it is our duty to "humanize industry."

The New York Court of Appeals has declared that "the inherent risks of an employment should in justice be placed upon the shoulders of the employer, who can protect himself against loss by insurance and by such addition to the prices of his wares as to cast the burden ultimately upon the consumer; that indemnity to an injured employee should be as much a charge upon the business as the cost of replacing or repairing disabled or defective machinery, appliances or tools."

Dr. Gustav Stresemann, a former prominent member of the Reichstag and a well-known economist, has just returned to Germany after a tour of the United States. Here are his words: "The

conditions in most American factories in respect to safety are simply horrible, and any German factory inspector would be astounded if he could observe the dangers to which the majority of workmen are exposed."

#### THE NEW LAW.

The Boynton Workmen's Compensation, Insurance and Safety Act, Chapter 176 of the Laws of 1913, superseded the Roseberry law on January 1, 1914.

#### COMPENSATION.

The new way of computing compensation, which will be compulsory, excepting for agricultural pursuits and household domestic service, is based on the nature of the physical injury or disfigurement, the occupation of the employee and his age at the time of injury. This will give some men more money than other men, according to the schedule based on the three essentials referred to. In addition, there is provision for pensions, at a reduced rate, for those who are permanently and seriously hurt and who are unable to follow their vocations. In order to meet this extra cost, which affects very few men, the compensation payments will not begin until two weeks after disability. The Roseberry law provided for a waiting period of one week. It is believed the addition of the extra week will pay fully for the pensions of those who have been eliminated from the industrial field.

#### MEDICAL.

The Boynton law requires full medical and surgical attention for injured wage-earners for the first ninety days. The theory of this section is that compensation may be saved if the injured person can be restored to efficiency as speedily as possible, and, outside of that, there is the humanitarian viewpoint that considers each man or woman engaged in industry as a national asset.

#### SAFETY.

The Safety Department of the new law is elastic in administration, following the Wisconsin plan. Hearings will be held at which both employers and employees will be represented, in conjunction with the safety experts of the Industrial Accident Commission, and afterward there will be issued rules, orders or regulations requiring preventive measures that will reduce the number of casualties in the various occupations. Wisconsin employers and employees have found this new way very satisfactory. It insures co-operation between all those interested and the Commission has authority as binding as law after the hearings have been held. Common sense and good judgment can both be used to advantage in protecting machinery and making places of employment safe.

Mr. C. H. Crownhart, Chairman of the Wisconsin Industrial Commission, was asked for his opinion of the safety provisions of the Wisconsin law, which have been in force for more than two years, and as there is little or no difference between California's safety law and that of Wisconsin, Mr. Crownhart's telegram is valuable at this time:

"Employers fully satisfied with safety and sanitation provisions of our law and manufacturing

associations are against their repeal. The Commission, by detailed investigation with expert help, is able to meet needs of employers intelligently. Instead of imposing burdens on employers we help them to save money. Employers realize this and we have their hearty co-operation. Our method has taken factory inspection and safety work entirely out of domain of politics and put the department on a purely business basis. Wm. George Bruce, as Secretary of the Milwaukee Manufacturers' Association, in a public speech said: 'I am safe in saying the work of industrial safety and sanitation of Wisconsin, which has been progressing in a most successful manner, has the good will and support of the manufacturing of the State.'

"C. H. CROWNHART,

"Chairman Wisconsin Industrial Commission."

#### INSURANCE.

Important indeed is the State Compensation Insurance Fund. The only practicable way for employers to protect themselves and to add the cost to the business is by carrying insurance. Realizing this, there are provided four methods: first, the State Compensation Insurance Fund; second, the regular insurance companies selling compensation coverage; third, mutual or interinsurance companies; fourth, the employer to carry the risk himself. These methods are optional. The object of the State Compensation Insurance Fund is to sell coverage at a fair rate that will make sure that the injured men and women receive all that the law calls for, and will also have the advantage of reasonable cost for employers.

Insurance rates are based on not only the hazard of the industry but the way that plants are safeguarded. The employer who installs all the protective devices possible, who places safety rails at the head of openings in floors and who takes all the numerous other precautions that are not only advisable but necessary, will be charged a lower rate than will the man who is careless in these respects. This means that there will be a premium for the careful and humane employer, and the cost of his installations for the protection of his employees will be repaid by the lower rates charged. The indifferent employer who is neglectful will have to pay a higher price for his insurance. As premiums are always based on the hazard of the industry, the prime object is to prevent all the deaths and all the injuries possible. This object is good for the nation, for the state, and it certainly should appeal to every man and woman, regardless of relations in industry.

#### STATISTICS.

Statistics will be carefully collected under the Boynton statute, so that the public may secure all the information possible concerning the industrial-accident situation. Not only will the facts and figures gleaned prove of general interest, but the insurance rates are based on the hazard of each industry, which makes accuracy in the Statistical Department especially important as regards cost.

In California during 1912 there were reported more than 600 deaths of an industrial nature. In 1913 the number of deaths was over 800. The statistics for each year convince the Industrial Ac-



cident Commission that fully 25,000 industrial accidents take place during the twelve-month period. More than one-third of these deaths and accidents are preventable, and each such death or accident constitutes a crime against society and inflicts grievous wrongs on individuals.

#### APPEALS.

Appeals may be taken from decisions of the Industrial Accident Commission to either the Supreme Court of the State or to the District Court of Appeal.

#### ATTITUDE OF THE COMMISSIONERS.

You will be interested to know that Mr. Pillsbury, Colonel Weinstock and I have sought for our appointive associates on the Industrial Accident Commission the most competent men and women we could find. From Stanford University we were successful in coaxing Professor Ira B. Cross of the Department of Economics to become our Secretary. C. W. Fellows of Los Angeles was chosen to head the State Compensation Insurance Fund. From Pennsylvania will come John R. Brownell to the important position of Superintendent of Safety. And last, but by no means least, we have for our Medical Director a worthy member of an illustrious house in the medical history of California—Dr. Morton R. Gibbons (applause). These men have not been asked their political affiliation. The Commissioners desire to administer the law in as creditable a manner as possible, and by introducing the merit basis we trust to achieve that end.

#### OF IMPORTANCE TO THE MEDICAL PROFESSION.

No group of men or women is more desirous of preventing the spread of disease and lengthening the span of human life than your fraternity. And to your credit be this said. To a layman it might seem that you would profit financially should sickness predominate in our community life, but the attitude of doctors the world over places the profession on the highest plane.

It is needless to ask the same splendid co-operation in facing the industrial-accident problem in the State of California. We know that this assistance will be given. The law will have to be tried out, but its sponsors know that all its provisions have been tested elsewhere and have not been found wanting. The members of the Commission will be glad to receive your suggestions for changes in the statute and to secure your unanimous support in administering it during the year ahead.

Naturally, to doctors too much emphasis cannot be laid on the medical and surgical sections. Other states provide unlimited attention for a given period of time. California sets the time at ninety days. The reason for this is that the best and cheapest form of compensation is to rebuild the injured worker regardless of cost. If there is a maximum, there may be a tendency not to furnish the most desirable attention. This best care is cheapest because when the man returns to his employment in the physical condition he would wish, compensation payments cease. The attractive part of the plan is that one of the state's citizens

engaged in productive work resumes his labors. So everybody wins when an industrial accident is mended well and expeditiously.

About this time the thought may come as to the relation of the doctor to his well-earned fee. The answer is that under compensation there will always be a fee for services rendered, while under liability the fees were few and far between because no provision was made for the large majority of injuries, owing to the absence of negligence.

As in Massachusetts, we propose to have the payments based on what would be charged the injured men and women should they have to pay the cost out of their own pockets. This is entirely a fair proposition. It is what you do right along. You take into consideration the financial ability of the patient to pay. If you did not continue this system under compensation, and charged the state and employers generally what "the traffic would bear," the result would be that the medical cost would be top heavy and the whole scheme would fall to the ground. Experience in other states shows that the cost per accident is not high.

We have consulted the best doctors in San Francisco, men whose names are known all over the land. They assure us that we are right in our position, and that the profession will endorse our stand.

Finally, aid us by cheerfully reporting on our blanks all industrial accidents. This may take a little time, but the aim is to find out everything possible about the entire subject, and you are just as much interested in that as we are.

I have to thank you for your courteous attention and for this opportunity to address you on a subject of importance to all.

#### MEETING OF THE MARIN COUNTY MEDICAL SOCIETY.

January 15th, 1914, 8 p. m.

The meeting was opened at 8:15 p. m. by Dr. O. W. Jones, President.

The following members were present: Dr. Howitt, Dr. Sullivan, Dr. Stowe, Dr. F. Hund, Sr., Dr. H. Hund, Jr., Dr. O. W. Jones, Dr. W. F. Jones, Dr. Dufficy, Dr. Dudley, Dr. Stone, Dr. Kuser and Dr. Mays.

The business of the meeting being a discussion of the Boynton Act and its consequences upon the medical profession of the state.

Motion was made and seconded to induce the State Society to make a fee list acceptable to the members of the State Society, it being the opinion that lay people should not take it upon themselves to regulate the fees of the medical profession.

Motion made and seconded that the members of this society will strictly adhere to the fees that have been in vogue in this county for years, and that the time-honored principle of the patient being allowed to choose his own physician should be absolutely adhered to.

There being no further business the meeting adjourned at 10 p. m.

A. H. MAYS, Secretary.

## ORIGINAL ARTICLES

## A PLEA FOR THE IMMEDIATE OPERATION OF FRACTURES.\*

By CHARLES G. LEVISON, M. D., San Francisco.

That the open treatment of fractures is now an accepted procedure is no longer disputed, and it is being rapidly adopted by those surgeons who were formerly most violent in their opposition. One point of the controversy as to whether fractures should be operated *immediately* or whether operation should be *delayed*, is still unsettled, and is the "raison d'être" of this paper.

Before entering upon the discussion of the operation, it must be emphasized that immediate operation should under no circumstances ever be attempted by anyone whose technic is not absolutely perfect, for the remarks that follow here are only intended for those operators whose surgical technic is above reproach.

The peritoneum on account of its liberal lymphatic anastomosis, is known to be the most tolerant structure to infection in the body, and experience with this tissue is no guide to the method that must be followed in immediate operation for fractures, for here the parts are very vulnerable and prone to infection. Recent hemorrhage with traumatized tissue offers a good pabulum for the growth of micro-organisms and it is obvious that a recent fracture is very liable to infection, so that it remains a point well taken by the opponents of operation who recognize the possibility of infection.

In answer to this opposition it is shown by Mr. Lane's experience, which I can confirm, that with the strictest attention to detail, infection can practically be avoided. Opponents to immediate operation maintain that 5 or 6 days at least, should be allowed to elapse for by this time the lymphatics are plugged or cofferdammed and the localized leukocystosis makes infection less liable.

The following, in my opinion, is of great importance in reference to immediate operation. In a paper<sup>1</sup> published two years ago I expressed the belief that the displacement of fractures is not due to the normal contraction of muscle such as has been generally maintained, but that the first deformity is due to the trauma and that reposition of the fragments if immediately carried out, is easy, the contraction of the muscles playing but a minor role. This observation is confirmed in the daily experience of every surgeon having to do with fractures, where it is seen that the difficulty of approximating the fragments increases in direct proportion to the time following the accident; in other words, the longer the time that is allowed to elapse the more difficult approximation becomes; this difficulty is due to the fact that the contraction is not one of normal muscular contraction, but that it is the result of the coagulation of the blood that has escaped into the tissues which produces an induration of the muscles and soft parts that makes manipulation of the bone difficult.

It should be mentioned in discussing the indica-

tions for immediate operation in fractures that only those fractures that have been produced by *indirect violence* should be operated. Fractures complicated with great traumatism to the tissues should not be operated immediately.

Experience has shown that when a fracture is operated upon immediately after it has taken place, the fragments are easily approximated as stated above, and if one has not had the experience it is surprising at the ease with which this can be done. As a consequence a smaller incision is made than is the case when the operation is performed later; as a result there is little traumatism of the tissues and less manipulation is necessary, which diminishes the tendency to infection.

*Treatment of Compound Fractures:* The consensus of opinion regarding this class of fractures is that there should be no operative interference, and that conservatism should be observed. Even if reduction is not possible operation should be performed at a later date, 15 days being the average time. My belief is that if possible, the wound should be allowed to heal *entirely*; the fracture can then be treated by operation in the usual way without any danger of infection; this procedure has been advocated by me in an earlier paper<sup>2</sup> which discussed the treatment of compound fractures of the tibia.

It must be emphasized that under no circumstances should a compound fracture be explored; the finger or instrument should never be introduced into the wound, but this should be given a first aid dressing and not disturbed further; when this is done it is astonishing how quickly these wounds heal as compared with the infected wounds that are so frequent when manipulation and exploration have been carried out.

*Indications for Operation:* It should be understood that operation is not advocated for every fracture, but only for those fractures which cannot be treated in the usual way. It has been repeatedly stated by numerous writers that there are many fractures that can be satisfactorily treated without operation, and there is no intent on my part to enlarge the indications for operation. There are, however, a certain class of cases and these form a large percentage of the fractures in which although an ultimate successful result is possible to obtain without operation, nevertheless there are factors of importance in this connection that must be considered, for example:

Given a laboring man with a fracture of the middle of the femur: In this form of injury a very good result is possible to obtain if it is treated by the conservative method but the period of convalescence will be much longer than if operation is carried out. As perfect approximation is the *exception* instead of the rule, the convalescence is delayed in proportion to the size of the callous formed, which is naturally dependent upon the apposition of the fragments. On the other hand with operation, approximation with primary union and little or no callous formation is obtained so that besides the rapid convalescence, the freedom from apparatus that must be constantly watched

\* Read before the St. Francis Clinical Society, San Francisco, April 25, 1913.

when extension is applied, is a very serious consideration that cannot be ignored. Another example is a patient with a fracture of the upper third of the femur with marked displacement as is usually the case; this requires constant attention for six weeks to obtain anything like satisfactory approximation and to overcome the shortening. During all of this time the patient is probably confined to his bed.

Compare this with an operation properly carried out where a cast is applied at the end of the first operation and which is allowed to remain for at least three weeks; the first dressing is done without any discomfort and subsequent dressings cause no annoyance. My experience has been that if the patients are given an intelligent idea as to the comparative merits of the procedures, there will be few patients who will not choose the operation.

The Bardenheuer method of treating fractures is an excellent one and when carried out by the originator the results are beyond criticism, but there is so much difficulty and detail associated with the proper application of the method that it becomes impractical in the majority of institutions, as well as with most patients. My impression is that Bardenheuer has a class of patients to deal with, who submit to his treatment with a much easier acquiescence than is the case in this country.

*Time of Operation:* Up to this time the most of the supporters of the open operation delay for 7 to 15 days before interfering on account of the danger of infection; by this time the muscles and tissues have contracted and have become so fixed that the replacement of the fragments becomes quite difficult and approximation which would have been easy during the first 24 hours has been converted into a procedure where a much greater amount of manipulation and trauma becomes necessary. Callous formation commences after ten days which complicates the situation.

Lane was one of the first to advocate immediate operation and I have followed his practice and am of the opinion that an operation when carried out under perfect technic is practically free from the danger of infection. This together with the ease with which approximation can be produced and maintained as compared with the operation performed at a later period offers the strongest argument in favor of the procedure.

#### *Details of the Technic:*

1. Lane's Dictum.
2. X-Ray.
3. Hemostasis.
4. Skin Disinfection.
5. Skin Protection.
6. Incision.
7. Approximation and Fixation of Fragments.
8. Drainage.
9. Closure.

As the success of the operation is entirely dependent upon attention to the smallest details, these will be separately considered.

*Lane's Dictum:* "There should be no handling of the tissues whatever."

Experience has shown that practically all fractures can be reduced with instruments and at no time is it necessary to introduce the finger into the wound.

Gloves are always worn and the finger should not be introduced into the wound as there is great danger of the glove finger being punctured by a spicule of bone. Our experience is that this is not an exaggeration of technic for the same results are not possible to obtain by any other method.

After a little practice it is surprising how readily operations can be performed with instruments. As no blood vessels are tied the finger is not introduced for this purpose. The muscle layers fall together readily because the fibres are generally only separated. The incision is made in the line of the extremity and in these regions there is little tendency on the part of the fascias to increase the width of the cicatrix so that these tissues are not sutured; if it is necessary to unite the fascia as in supra-condylar fracture of the humerus or fractures of the femur, catgut can be used and the sutures tied with clamps. The skin is brought together with Michel clips which can be applied without manual contact.

*X-Ray:* It is axiomatic that the diagnosis of fracture should be made by means of the X-ray. The routine examination is not accompanied by any manipulation of the fragments. This point is in direct opposition to the views of many surgeons who advocate conservation, for they maintain that the diagnosis should be made before the patient is submitted to the X-ray. It is essential that a correct diagnosis should be made prior to the operation; any procedure that necessitates the handling of the fragments must be productive of harm, so this can only be avoided by the X-ray and as it is well known that even the most skilled diagnosticians frequently find it impossible to make a correct diagnosis in this chapter of surgery, why waste unnecessary time in the attempt?

*Hemostasis:* Hemostasis is not employed in the majority of fractures. The operation with the "Esmarch" may be easily performed but the secondary oozing due to vasomotor paralysis permits the accumulation of fluid to a much greater degree than if the bandage is not employed and as drainage is never used it is important to limit any accumulation of serum. There is one fracture, in my opinion, in which the employment of the tourniquet is recommended, and that is the spiral fracture of the tibia. This fracture is at times so difficult to reduce that hemostasis is thought advisable as it makes a clear operative field and hence avoids the introducing of the finger. The bandage should always be applied before the skin is disinfected for if it is used after disinfection of the skin, contamination becomes easy. Long-handled Oschner hemostats may be applied during the operation; with their sharp bite the blood vessel is generally occluded. Ligatures are never used so that there is no necessity to introduce the hands into the wound for the purpose of tying ligatures.



**Skin Disinfection:** In the majority of fractures the patients are dirty and require a considerable amount of cleansing before anything surgical can be done. If possible the leg should be shaved dry and it should then be scrubbed with a solution of iodine with benzine 1 to 1000; 5% tincture of iodine should then be applied in the usual way. The benzine has the effect of removing the dirt and grease from the skin and it does not interfere with the subsequent disinfecting effect of the iodine as does soap and water, which should never be used.

**Skin Protection:** The most important part of the entire technic, in my opinion, is the protection of the field of operation against contamination. First the limbs must be covered with sterilized towels which are fastened by hooking them to the skin by means of small vulsella; there is no danger of infection whatever when these are used on the sterilized skin and they fix the towels so that they never slip.

It is important to scratch the skin with a sharp needle to mark the situation and the length of the contemplated incision. If the towels have been attached to the skin, the landmarks and the position of the fragments have been obliterated, and as handling of the skin is prohibited it is essential to know where the incision is to be made; this is shown where the skin has been scratched in a very satisfactory way.

Napkins must then be attached by vulsella close to the skin scratch, so that only a small area of skin is visible on each side of the scratch, then the incision is made over the scratch without touching the skin with the hand; this incision is carried through to the muscle; gauzes are then attached to the fascia by four-pronged right-angled vulsella in such a way that they do not go through the skin so that this structure is entirely excluded from the field of operation. In this way micro-organisms that may be forced out of the upper layers of the skin during any manipulation are not thrown into the wound but are absorbed by these gauzes.

I believe that it is largely due to this part of the technic that we are able to obtain such perfect results, for it is well known that the majority of our wound contaminations come from the skin.

**Incision:** The position and size of the incision is determined by the skin scratch.

**Length of Incision:** It might be stated epigrammatically that the shorter the time after the accident that the operation is performed, the shorter will be the incision.

**Approximation and Fixation of Fragments:** The following principles should be observed in the proper approximation of the bone fragments.

1. The plates in general use for recent fractures (with the exception of vanadium steel) are much too thick. Proper approximation can only be accomplished by mobilization and extension which permits the fragments to come together. The plates are really intended to act as splints and

should not be expected to maintain approximation by their great thickness and tensile strength.

2. In order to obtain perfect approximation the fragments remain together without any displacement, then the plate is applied. As there is no tendency on the part of the bone to displacement if satisfactorily reduced, the plate is not subjected to any strain. These remarks apply only to recent fractures where mobilization is easy.

3. With the patient on the pelvic elevator and with a perineal upright that causes counter-traction and extension of the leg by means of mechanical traction that gives a steady pull, plating of the bone is easy and hardly any of the instruments advocated to hold the bone in position are necessary. The subsequent dressing and plaster spica is easily applied as the patient is not resting on the table so that there can be no shifting of the bone as is frequently the case if the patient is lying on the table under extension, for the bone is apt to slip with the movements of the patient during the time that the plaster bandage is being applied.

The subject of plates and screws and the apparatus used in the operation for bone fracture will not be taken up.

**Drainage:** This should never be employed. Experience has shown that it is not necessary and there is always danger of infection in the track of the tube. With the bone in position and a firm well applied plaster bandage the pressure is equalized so that healing is perfect without any accumulation of serum.

**Closure:** There is no necessity to bring the muscles together by suture as the incision is always made in the direction of the muscle fibres which fall together when the wound is closed.

The periosteum need never be sutured and even if this is attempted, experience has shown that it is frequently impossible to suture this structure satisfactorily.

With the incision made longitudinally, the fascia even if it is not sutured, shows no tendency to cause widening of the scar so that all that is necessary is to close the skin with clips which obviate the necessity of introducing the hand into the wound.

#### References:

- 1 Observations Upon the Open Treatment of Fractures, Surgery, Gynecology and Obstetrics, February, 1911, pages 162-65.
- 2 Treatment of the Spiral Fractures of the Tibia, California State Journal of Medicine, May, 1913, page 188.

### A NEW TREATMENT OF POLIOMYELITIS.\*

By D. H. MOULTON, M. D., Chico.

In presenting this paper to you, I wish to offer for your consideration that which seems to me to be of great import at the present time.

We all know from our observation and from our readings what terrible afflictions the recent

\*Read before the Sacramento Society for Medical Improvement, December, 1913.

edipemic of poliomyelitis have wrought upon the babies and children and even adults of this and other countries. We see the effect of this dread disease all about us and aside from plaster paris, braces, and operative procedure, we have been almost powerless to help the little ones, and restore them to normal, so that they might take their respective places in the great caravan of life and be normal, useful men and women.

It is estimated that there are over a million children in the United States growing up somewhat deformed as the result of this disease; and now the light seems to be shining through the clouds of uncertainty, which have always hung over these cases.

At the Rockefeller Institution which I visited last year, a great work is being done; trying to get a serum or antitoxin or vaccine to prevent this disease in its advance on our children. At the institution I saw numbers of little sufferers in the fever stage and later these same little ones were sent to the different orthopedic hospitals to be worked upon with plaster and braces; and later sent out into the world as incurable.

There seems some hope now for the little ones, and the object of this paper is to present to you an outline of this rational treatment and urge you to give it a trial and give the babies the benefit of it, for many have been cured and many more will be restored to normal by its use.

Last month I spent in Chicago with Dr. Roy Bernard, the father of this treatment, and many cases he showed me, convinced me that there was truth and merit in the treatment. Case after case I visited, talked with the parents of the children who had had great deformities, and saw them cured and normal. This treatment to be sure is in its infancy, but from the records of cures, I believe that every child afflicted is entitled to the treatment. It is not claimed that every case presented will be cured, but the percentage of cures of cases already treated is so large that I repeat, "Every afflicted child is entitled to the treatment."

It is not my desire to go into the symptoms, etiology, bacteriology, or even the minute pathology of this disease; suffice it is to say that we are still ignorant as to whether the results of this disease are produced by the direct presence of the micro-organism in the nervous tissues or indirectly by means of a toxin. Osler says, "It is clear from the behavior of the ganglion cells, that these are not specifically susceptible to the influence of the virus, but rather suffer from the effects of inflammatory changes in surrounding tissues."

In some of the fatal cases, live cells have been found in the cord at the point of inflammation. Working along these lines, Dr. Bernard figured that if some means could be applied to nourish these cells of the gray matter of the spinal cord and brain stem, there would be a regeneration of the axis cylinder processes and a growth of the atrophied muscles.

Realizing that the severe inflammatory process

in the cord has caused many adhesions, with a resultant lessened blood supply, it seemed plausible to get a method to attempt to break up these adhesions and yet, not do any more damage to the cord. It was found that by the actual stretching of the cord, this could be accomplished; and the remarkable cures which I have witnessed were brought about by this simple, yet scientific method. At first weights and pulleys were used, but two cases showed hemorrhage, which proved that the shock was too much for the cord. After much experimenting it was found that the best results were obtained by suspending the body with the support just above the affected portion of the cord. In cases of lumbar affection, the support is applied over the 9th, 10th and 11th dorsal, which corresponds to the largest part of the lumbar enlargement of the cord.

In case of cervical affection, the support is applied over the 2nd, 3rd, 4th and 5th cervical vertebrae, so that the extension will be at the 6th cervical, which corresponds to the largest part of the cervical enlargement of the cord.

The technic of the treatment is very simple, but must be carried out carefully, and it must be understood that the longer the time elapsed between the onset of the disease and the beginning of treatment, the slower the results. But if there are any remaining cells at all, you may certainly expect good results. The treatments are given every 2nd or 3rd day and it may be necessary to cover a longer period of time; that is, several months. Some of the cases develop after the first few treatments, a return of the initial symptoms: high fever, vomiting and diarrhoea. In these cases it was found the results were very rapid and the child made quick recovery.

In case the legs are involved the treatment is given at the lumbar enlargement, the belt being fastened so that the groove in back of the belt fits over the 9th, 10th and 11th dorsal, the rings in front of the belt should be in the mammary lines. When the child is suspended the belt acts as a fulcrum and we get the extension at the proper place. For the first minute the child is allowed to hang quietly, during which time there is first a natural resistance of the muscles, followed quickly by a complete relaxation; as soon as this relaxation occurs the body is swung forward and backward so as to get the bend at the 12th dorsal, then slightly from side to side, always supporting the child with one hand on the back of the belt. This should be done for two or three minutes.

In treating cases where the arms are involved the extension of the spine should be at the 6th cervical vertebrae. Have the patient lie on back, place your fingers on each side of the spinous process of the 2nd, 3rd, 4th, and 5th cervical vertebrae, making an extension that will almost move the weight of the body from the table for from one-half to one minute; or to get more extension, stand in front of the patient, place the tips of your fingers on the transverse processes of the 2nd, 3rd, 4th, and 5th cervical, gently extend the cervical region until the patient is

lifted from the floor, gently throwing the junction of the cervical and dorsal; this makes the extension of the 6th cervical, which is the largest part of the cervical enlargement of the cord. Swing the patient gently forward and backward, then from side to side for one-half minute.

The object of the treatment is to obtain an increased blood supply to the involved areas, which naturally aids absorption and stimulates vasomotor function. This in turn nourishes the cells, with a resultant regeneration of the nerve and a growth of the atrophied muscles.

In closing I wish to give a few brief histories of a few of the many cases I saw last month.

1. Julia Ur, age 18 years, onset January 6th, 1913. Right leg completely paralyzed with atrophy, including the hip muscles. Treatment began March 5th. The muscles of the leg have been entirely restored and the gluteal muscle has filled out to normal.

2. T. B. Girl age 3, onset Sept. 8th, 1912. Treated at Cook County Hospital for two months without any improvement. Treatment commenced Nov. 15th, 1912. Some motion was noticed three weeks after. Could walk two months later and was pronounced cured in three months.

3. J. B. C. Boy age 3, onset July 28th, 1912. Atrophy of both arms and legs. Legs drawn up in flexion. Treatment commenced May 1st, 1913. After 11th treatment muscles of legs relaxed. Could walk well and use arms by Aug. 1st, 1913.

4. Catherine E., age 11, onset August, 1907. Extended foot. Left leg atrophied and foot talipesed. Treatment commenced Jan. 25th, 1913. After third treatment toes relaxed; after twelfth treatment general improvement. After sixteenth treatment could jump rope. Was pronounced cured April 12th with all motions normal.

5. Virginia M. (my own child). Onset Sept. 28th, 1910. Paralysis of all muscles of right leg below the knee and of quadriceps extensor above the knee. Treatment commenced Sept. 18th, 1913. Has now had about 20 treatments and much improvement is noticed.

I now have a clinic at my office in Chico at which I am treating a dozen cases, and some of these cases have shown a marked improvement during the month I have been treating them.

I will be very pleased to instruct any physician who might care to visit my clinic, so that he might treat his own cases at his own office.

## SURGICAL COMPLICATIONS, TREATMENT AND PREVENTIONS.\*

By C. P. THOMAS, M. D., Los Angeles.

The life of an active practitioner of surgery is not, as is supposed by some, one of constant bliss and sunshine, for in addition to the enormous amount of mental strain he is under while actually operating, because of the gravity of the cases he undertakes, and the risks to which he must submit both himself and patients, he must be constantly on the outlook for the unexpected to follow in the way of complications, many of which, so far, I believe, are unavoidable. Rapid, uninter-

rupted recoveries are so frequent after operations that I fear we sometimes forget the grave and serious conditions that may occur.

I will endeavor in this brief paper to outline some of the more common unfortunate complications which may occur and a few means of prevention.

Admitting that every preliminary precaution has been taken in advance of the operative procedure, in the way of careful examination of the physical conditions, of the urine, feces and blood, etc., nevertheless any of the following unforeseen complications may occur:

1. Death from Anesthesia.
2. Death from Acute Nephritis.
3. Death from Pulmonary Embolism.
4. Regional Death from Arterial Thrombosis.
5. Death from Hyperthyroidism, from an Unrecognized Graves' Disease.
6. Death from Hemorrhage from the Mucous Membrane of the Alimentary Tract.
7. Phlebitis, With or Without Suppuration, With Possible Death.
8. Parotiditis, With or Without Suppuration.
9. Acute Dilatation of the Stomach.
10. Acute Gastritis.
11. Pneumonia, or Acute Hypostatic Congestion of the Lungs.
12. Non-Union of Bones or Soft Tissue.
13. Cystitis and Pyelitis.
14. Post-Operative Hernia.
15. Delirium Tremens.
16. Unrecognized Lesions.

During the past twenty years, the writer has had at least one patient with each of the above-named complications, and some of them have been seen many times following some surgical procedure, which may or may not have been severe, and he will endeavor to describe them briefly, with suggestions for their prevention and treatment.

1. *From Anesthesia.* In 1897, I lost a large, bony miner from chloroform, less than one drachm having been administered, on an open mask, and before the operation had been begun. He had been on a protracted spree, was in poor condition for the anesthetic, and was suffering from tubercular osteitis.

I thereupon abandoned chloroform and have since used gas and ether exclusively. I have had ether administered to patients in large numbers, with severe heart lesions, and to others who had chronic nephritis, without its producing any apparent increase in the heart or kidney trouble. Spinal analgesia has but a limited field of usefulness and Crile's combination analgesia may yet be more generally adopted.

2. *Acute Nephritis.* This has followed surgical procedures, regardless of the anesthetic used, in a small percentage of cases. Some have been severe with complete suppression, and have died; others less severe and have recovered. I am of the opinion that nephritis can best be avoided by keeping the patient and operating room warm and free from

\* Read before the Los Angeles County Medical Association, October, 1913.



drafts; making the operation as short as possible; giving the least amount of anesthetic that is consistent with good work; doing as little manipulating as possible of the intra-abdominal organs and providing ample drainage for infected cavities to prevent absorption.

Good team work on the part of the surgeon and his assistants is also absolutely essential to avoid the frequent occurrence of this complication, and such work can not be maintained if he be an infrequent operator, or is constantly changing his assistants or place of operating. A thoroughly trained anesthetist should be a part of the team.

3. *Pulmonary Embolism.* Death from this complication has occurred several times; once on the fourth day after a vaginal hysterectomy; once on the second day following a compound fracture at the ankle joint; once following perineal prostatectomy, and other deaths have occurred in which it was believed, but not proven, that this condition existed. I have no suggestion for prevention.

4. *Arterial Thrombosis.* This caused complete obstruction of both popliteal arteries once, following vaginal hysterectomy. Both legs became gangrenous from the knees down; the patient was too weak and anemic to permit double amputation, and died from exhaustion a few days later. I have no suggestion for prevention of this complication.

5. *Hyperthyroidism.* This has been observed a few times, coming on a few hours after some superficial operation in which there was no possibility of unseen hemorrhage, and with no other complication, death usually taking place the second or third day. During recent years, since the diagnosis and treatment of Graves' disease have been more thoroughly understood, I have had no trouble from this source.

6. *Mucous Membrane Hemorrhage.* Persistent vomiting of blood, and melena, have claimed three patients from me, following simple abdominal operations. All of them had been operated for fairly severe appendicitis. The treatment of the appendix stumps was such that the hemorrhage could not possibly have come from that source. The hematomesis came on in two of them but a few hours after operation, and death in about eight hours.

The third one came on the twenty-first day after the operation, and the post-mortem showed the blood to have come from the entire mucous tract. Authorities differ as to the source of alimentary tract post-operative hemorrhage, some claiming gastric or intestinal ulcers, others that it comes from simple oozing from the mucous membrane where no ulcer exists. This was certainly the condition in the one we examined post-mortem. The free administration of horse serum to all persons suspected of being bleeders, would probably prevent this complication.

7. *Phlebitis.* This condition has occurred in a small percentage of laparotomies between the eighth and twentieth days, particularly in simply appen-

dectomies with no apparent wound infection, and the left femoral vein is the one usually involved.

The wound infection theory as to the cause of this complication, and the fact that the left external iliac vein differs somewhat, anatomically, from the right in its relation with the artery, is probably the correct one. The early recognition of the complication, with proper treatment by ice bags, rest and elevation during the acute stages, will shorten its duration very greatly. I have never seen this form of phlebitis go on to suppuration, or have a pulmonary embolism, but recovery is often very painful and slow.

8. *Parotiditis.* This complication has followed a number of times. Those recognized early, and treated by ice-packs and early puncture, and which have not gone on to suppuration, have recovered, while those beginning at the end of the first forty-eight hours after a very septic operation, with suppuration, usually terminate fatally.

There are four theories as to the cause of this complication. One, that it is through the sympathetic system, because of the well-known relation existing between the ovaries and the parotid glands. This is, however, scarcely tenable, since parotiditis is an occasional complication of operations not involving the ovaries. Two, that it is a manifestation of a general septic condition. This is not always true, however, since in several cases observed by me, the infection was regional and not general. Three, that of infection through the ducts from the mouth. The mouth is notoriously foul and infective following septic surgical operations and one can easily conceive of an ascending infection thus taking place. Proper care of the teeth and mouth should especially be enforced just before and after the operation. Four, that of metastasis. This is, I think, also a feasible explanation. Traumatism by a careless anesthetist is a possibility.

9. *Acute Dilatation of the Stomach.* This usually comes on the first three days after an abdominal operation, and is a grave symptom, manifested by frequent vomiting of very large quantities, with evidence of great shock and exhaustion, and is apparently unavoidable. Treatment consists of early stomach lavage, sitting posture, enemata to relieve gas from the lower bowel, and heart stimulation. Cathartics are contraindicated for this condition, until after the dilatation symptoms have subsided.

10. *Acute Gastritis.* This condition comes on soon after operation, due probably to swallowing saliva and mucous heavily laden with ether, and has been observed in a number of cases, manifested by severe acid vomiting in small quantities, beginning from thirty-six to forty-eight hours after operation, continuing for two or three days without peritoneal inflammatory symptoms. Treatment consists in stomach washing and the administration of a small dose of morphine and atropine hypodermatically, repeating in five or six hours if necessary. These last remedies are, I believe, the ones to which the greatest credit should be given, morphine allaying the irritability of the stomach

and the atropine lessening the amount of secretions.

11. *Pneumonia and Hypostatic Congestion.* The latter condition has been observed quite frequently, especially in old people who have been submitted to severe surgical operations. They can be best avoided by the sitting posture and frequent position changing. The administration of morphine and atropine preceding the operation which lessens the quantity of ether necessary, and dries up the secretions of the mouth, thus preventing filling of the lungs with mucous discharges, is, in the writer's opinion, a good means of preventing post-operative pneumonia. The stomach should also be empty to prevent vomiting and inhalation of stomach contents. Drafts should be avoided, and the chest, neck and arms be well covered by warm clothing for several days following the operation.

Septic pleurisy, perhaps by metastasis has been observed two or three times following operations for severe pelvic infection, once causing death.

12. *Non-union of Bones.* This is usually due to one or more of the following conditions: Non, or imperfect coaptation of fractured ends; improper immobilization; infection from without or within; syphilis of tuberculosis.

*Non-union of Soft Parts.* This is generally due either to inaccurate coaptation of tissues, infection, disease of the pancreas, excessive suture tension from hematoma, swelling, carelessness in suture tying, or intra-peritoneal distension, or, it may occur in persons greatly reduced by long continued illness.

The writer has had three abdominal incisions open, twelve days after closure. Immediate resuture with through and through silk worm gut, without anesthesia has been followed by recovery in all, but with one hernia. The writer believes that catgut closure alone of the ordinary abdominal incision without fascia overlapping is insufficient and should be reinforced by wormgut left in ten days.

13. *Cystitis.* This is usually due to careless, rough or unclean catheterization, but is sometimes due to ascending infection, from lack of cleanliness of the vulvar region. Pyelitis is probably secondary to cystitis by ascension, but may be hematogenous. The prevention of cystitis consists in the avoidance of catheterization when possible, otherwise by careful, clean catheterization, followed each time by irrigation with a saturated boric solution. When present, treat early in injecting one drachm daily of ten per cent. argyrol solution into the empty bladder. When due to colon bacillus, Coli vaccine mixed strains should be used.

14. *Post Operative Hernias.* These are due either to infection, preventing primary union, improper coaptation and suture of tissues, including improper suture material; incisions which cut across the muscle fibre instead of along their course, or long lateral incisions which destroy the nerve

supply, causing atrophy of the muscles between the incision and median line.

Excessive muscular action too early may cause hernia, even after good union. The writer has no sympathy with the "very early out of bed and to work" advice of some surgeons, and I believe in the most accurate coaptation of abdominal fascia with figure eight wormgut stitch, without the use too many buried sutures.

15. *Delirium Tremens.* This is not an uncommon complication following operations, even in young persons who have been heavy drinkers. It can probably be best avoided by keeping the patient on a given amount of liquor for the first week after operation.

16. *Unrecognized Lesions.* Several deaths have occurred from alimentary tract stenosis, either malignant or simple, when the operation was done entirely for the relief of some other trouble. At least three patients have died from pyloric or duodenal stenoses which were not suspected before, or discovered at the time of the operation.

Chronic narrowing of any portion of the tract below the stomach, if not corrected, will increase and become more acute after an abdominal operation, because of the general intestinal paresis, stagnation, etc., which invariably follow. The remedy then is reasonably liberal incisions, with careful examination of all intra-peritoneal organs whenever possible, with immediate resort to any steps necessary to remove additional lesions or to correct the deformities resulting therefrom.

One of my objects in presenting thus briefly the above sequela and complications of surgery is to warn the surgeon against promises of sure cures.

The shock to the relatives of a patient who dies suddenly from any of the above complications is always severe, and is much worse if they have been told that there was no danger, and a promise of an early recovery made.

One of America's foremost surgeons said to me early in my career, that life was hardly worth living for a surgeon until his reputation was such that people would permit him to operate without first promising a cure, or making the statement that there was no danger from the procedure.

It is the writer's custom to invariably reply to the question, Is there any danger in this operation? that every operation is attended with some danger, and endeavor forthwith to impress it upon them by stating just about what the death rate is, or has been in his hands from the procedure advised.

We must admit that even operators of the greatest experience, still have these unforeseen complications and deaths, and while, in our time, we will probably not be able to prevent all of them, it is my hope that some of them will be avoided, and that in the meantime our friends of the laity may become so well informed regarding the unforeseen complications of surgery that a reasonable toleration on their part will make the work of the operator somewhat easier.

## PRESENTATION OF PATIENTS.

CONGENITAL DISLOCATION OF THE HIP AND EXTENSIVE SKELETAL TUBERCULOSIS.  
RADIOGRAM.\*

By HARRY M. SHERMAN, M. D., San Francisco.

A. C., aetat 3 years in 1897. Sent to me at that date by the late Doctor Henry Gibbons, Jr. The boy had a congenital dislocation of the right hip, with anterior location of the femoral head. A manipulative reduction was easily done, and proved to be stable. Eight months afterwards, when the boy was up and about, I found a kyphos, evidence of a vertebral tuberculosis. He was put on a Bradford frame for a year, and then was gotten up in a jacket. Four months later he evidenced a tuberculosis of the left hip, and went back on the frame

three years after its appearance it ruptured, emptied and finally healed. From the beginning of treatment for the congenital dislocation to the healing of the spinal abscess was fourteen years, and for the past two years he has been well and gaining in weight and strength.

He has a very short trunk, because of the badly deformed and extensively diseased spine, but he walks well and not without grace. The hip which was dislocated shows—in this radiogram—a short femoral neck and a large femoral head in a broad and shallow acetabulum, but as a joint it has a wide range of motion, and is a strong and useful joint. The hip which was the seat of a tuberculosis shows—on the radiogram—that the femoral head has been destroyed and the femur is high in the ilium, but, again, this limb is strong and useful and has an ample range of motion. The radio-



Right hip shows stable reduction of congenital dislocation. Left hip shows healed hip joint tuberculosis with absorption of the femoral head and a competent limb.

with traction on the hip added. Here he stayed eight months and then was again gotten up and was permitted to use his left leg. He took advantage of this to fall and wrench the hip, and had to be put into a spica-jacket plaster of paris apparatus. In this he did badly and was put back on the frame, with hip-joint traction for another year. Next he was up in a combination brace, a New York Polyclinic type of hip-joint traction brace and a Taylor posterior lever spinal brace. This he wore a year, and when it was taken off he was free from symptoms of active disease and remained so for two years. Then he had a recrudescence in his spine and the spinal brace was put on again, and was worn between two and three years, and during this time he developed a tuberculosis of a pisiform bone of the carpus. This I excised, and the place has remained healed. However, that same year he had evidence of pressure on the cord, and a spinal abscess appeared. I aspirated this several times, but could not control it, and

gram shows the end result of the two major lesions of the hip in children, a congenital dislocation on one side, and tuberculosis on the other—a very unique showing on one plate.

#### CARCINOMA OF THE RECTUM REMOVED FOUR AND A HALF YEARS AGO; HYPERTROPHIED PROSTATE RECENTLY REMOVED FROM THE SAME PATIENT. METHOD OF AFTER-TREATMENT OF ENUCLEATION OF THE PROSTATE.

T. M., aetat fifty-nine, was sent to me in 1908 by Doctor W. B. Lewitt, having a carcinoma of the rectum. The tumor was annular, 7-8 cm. from the external sphincter, not obstructive nor painful, but it was ulcerated and was bleeding. I operated at the University of California Hospital, doing first a laparotomy for exploration, to see if metastases could be found. As there were none, and as a lymphatic gland which I removed from the pelvis was normal, I did a left iliac colostomy by Ward's method, as described by Moynihan. This was a

\* Read before the San Francisco County Medical Society, General Meeting, October 14, 1913.



wholly satisfactory procedure; it made a good spur, and delivered all the feces on the surface, none passing the spur. A week later I did a Kraske, removing the tumor and some rectum, and fortunately the carcinoma only affected about 4 cm. of the rectum longitudinally. In closing, I made an end to end suture of the rectum, and also closed the incision over the sacrum. I think this last was an error, for the wound suppurated and was slow in closing, but through most of the time the man was in active business. When the sacral wound was soundly healed, I closed the colostomy, and the rectum and anus at once resumed normal function, and there has been no interruption for the four and a half years since the operation, and no recurrence of the carcinoma, either locally or by metastasis.

In July of 1913, after an indefinite period of prostatism, complete retention supervened. The prostate was found enlarged to a moderate degree, the right lobe being the larger. The gland was firm, not hard; was smooth, not nodular, and felt like a normally enlarged organ. Catheterization was difficult, because of a tortuous prostatic urethra; it was only practicable in a surgeon's hands by a silver catheter, and would be quite impossible for the patient himself. For this, and for the reason that I believed his condition after an operation would be far better than it could be if catheter life was instituted, I did an enucleation of the prostate. This was done at St. Luke's Hospital, July 24, 1913. I did a median perineal section; entered the prostatic capsule at the apex of the gland, and easily enucleated each half of the organ. There was no enlarged median lobe. The bladder was washed out on the operating table. I did not pack the wound in the perineum.

That same day there was retention, due to clots in the prostatic urethra, and catheterization was necessary, and then the tying of a soft catheter in the bladder. This was left in three days and then slipped out, and was never replaced. No irrigation of the bladder was practised. No further instrumentation has been permitted.

Some urine passed through the urethra on the eighth day, and on the fourteenth day the wound ceased to drain the bladder, and all urine was voided naturally. The healing of the wounds of incision and enucleation should be called normal healing, and since then function has been normal.

The laboratory reported the enlargement as due to "fibromyoma of the prostate."

There was no sign of malignancy.

The point I wish to make is, that, except for the catheterization rendered necessary by the retention because of clots, there was no instrumentation, and there was no bladder irrigation at any time after the operation.

Alexander used to drain the membranous urethra with a tube. Bryson uses a large perineal tube, and packs in addition, to control hemorrhage. Horwitz used to tie in a catheter. Young uses packing to control hemorrhage, and much continuous bladder irrigation to prevent clot formation. The packing is removed eighteen hours after the operation, and the tubes for the bladder irrigation 4-5 hours later. His perineal wound closes sometimes in five days—frequently in two weeks, and usually in three weeks. Judd drains the bladder with a tube, and notes that, after the removal of the tube, the bladder becomes continent by means of the internal sphincter, even before the perineal wound has closed.

It seems to me that drainage in these cases is unnecessary, except in the case of a post-operative retention, such as I have described. Under all cir-

cumstances I should think tube drainage in these cases is like tube drainage of a tuberculous abscess—a definite invitation to infection. I feel very much the same about the passage of sounds, which is advised and practised by some. It is an unnecessary and therefore a deplorable invasion of a healing wound, leading to a disturbance of parts and easily to infection. Healing occurs normally in these cases, if the parts are let alone, and with a proper perineal wound and urine carrying urotropin, drainage and irrigation are automatic. This is an additional witness to the wisdom of the late George Chismore, who protested against irrigation of the bladder under all ordinary circumstances, and as a routine method of treatment; not so much because of infection as because the patients whose bladders were frequently washed out did not get well.

I add these other cases in which I have followed, in general, the plan of no packing, no drainage, and no post-operative instrumentation:

St. Luke's Hospital. W., aetat sixty-seven, 1908. Transverse curved incision, convex forwards. Enucleation of the gland. No packing, no drainage tube. Some urine through the penis in two days, and more on the fifth day. In this case—done in 1908—I tried to pass sounds, but could not get one into the bladder, and the failure demonstrated the inutility of the sounds. No bladder irrigation was done. The man had control in seventeen days, and had no dribbling after twenty days.

St. Luke's Hospital. T., aetat sixty-five, 1909. Median perineal incision. Enucleation. No packing, no drainage tube, no sounds, no bladder irrigation. Control in eight days.

The Katherine Sanitarium, Santa Rosa. R., aetat sixty-five. Patient of Dr. J. W. Cline, 1912. Median perineal incision, enucleation. No packing, no bladder irrigation, no sounds. Bladder partially continent on the third day; patient urinated on the fifth day, colorless drainage on the tenth day. On the twelfth day, following a stool, he had a hemorrhage from the bladder, and then the wound required packing. This was left in for two days, and four days later he was passing urine only by the urethra.

After the hemorrhage the patient informed Dr. Cline that he had always bled considerably and long after any cut, so that it is fair to infer that he had some degree of hemophilia, and some slight injury, due to the passage of a large stool, had produced an excessive bleeding.

After the hemorrhage was controlled, his recovery was without incident.

I find D. W. Basham, Wichita, Kansas, has written thus on this phase of the subject, in "The Medical Herald," July, 1913:

"If the drainage looks red it is well to remember that a very small quantity of blood will color a large quantity of water."

"Most important of all, the bladder should not be irrigated at all nor at any times during the convalescence. It serves no good purpose to wash the clots out of the bladder. It is distinctly harmful and even dangerous to remove the protective coagulum from the mouths of the torn vessels and open up the field of operation and keep it open by passing a forceful current of water repeatedly through the bladder either from above or below."

"I have now had a sufficient number of consecutive cases treated without post-operative irrigations to prove to my satisfaction that they are not only unnecessary to the welfare of the patient, but that they are actually productive of secondary hemorrhage and are, therefore, fraught with danger."

"There is, as a rule, no need whatever to pass the sound."

#### Discussion.

Dr. M. Krotoszyner: As regards the differential diagnosis of ordinary hypertrophy and cancer of the prostate my own experience has taught me that

we must not rely too much upon one or even a group of clinical symptoms which apparently point to malignancy. Excessive bleeding, various paresthesias, especially pain radiating towards the lower extremities, severe dysuria, hard consistency and irregularity in the shape and size of the gland, marked cachexia: all these symptoms may either singly or in combination be found in ordinary hypertrophy. While it is true that, under certain conditions, a pretty safe diagnosis of cancer can be made from the clinical observation, I would, nevertheless, warn against overestimating the value of clinical tests from a differential diagnostic standpoint. I recall, in this connection, the case of a colored man whom I had the opportunity to observe several years ago and in whom, on account of excessive bleeding and various paresthesias, I made the diagnosis of cancer of the prostate. The patient was operated upon by Dr. Sherman at the University Hospital; the prostate was shelled out very easily in one piece and presented the type of a benign hypertrophied gland. On account of the uncertainty of the clinical diagnosis, Hugh Young of Baltimore has lately developed the mid-operative diagnosis on an excised piece of the gland. His statement, that a rasping sound made by the knife cutting through the prostate tissue, to be characteristic of cancer seems to be worthy of consideration. I fully coincide with Dr. Sherman in the stress which he laid in his paper upon the avoidance of post-operative instrumentation. Many years ago I treated, in conjunction with the late Dr. Goodfellow, a man of 72, in whom the clinical diagnosis of prostatic hypertrophy was made, which, though, after prostatectomy, in accordance with the pathological report, had to be changed to prostatic cancer. The patient made an excellent convalescence. About three weeks after the operation I passed a steel sound and 24 hours later the patient had a severe chill, several other and severer chills ensued and the patient died within five days under uremic symptoms, the condition probably being due to acute ascending renal infection. Since that time I have never, in the few perineal operations I have done, introduced a metal instrument. I have followed the same routine in my supra-pubic prostatectomies, which I now invariably perform, where I let the wound heal by expectant treatment. Dr. Sherman's remarks upon the late Dr. Chismore's abhorrence of excessive bladder-washes have recalled to my mind many pleasant reminiscences of this genial man and rare physician. Dr. Chismore was an excellent observer, and those of us who were fortunate enough to be thrown into continuous professional contact with him, quite often profited more from his teachings than from the perusal of text-books.

Dr. M. Silverberg: I think it quite advisable in every case of prostatectomy to wash the bladder. If clots be left in, after two or three months—perhaps when you think the patient has recovered except for a persistent cloudiness of the urine—you may be called to see him at night on account of intense burning in the urethra and a persistent desire to urinate, which will finally be alleviated by the passage of a clot; it is very likely to show a calcareous deposit. I think it advisable to irrigate the bladder after every prostatectomy until one may be reasonably assured that there are no clots of consequence.

In regard to packing the perineal wound, I think it becomes infected whether or not you put gauze into it, owing to the proximity of the anus. The structures of the perineum are such, however, that they take very good care of infection and there is little danger.

I cannot reconcile myself to any such broad statement as that the bladder ought not be washed. There are instances where it is advisable; in the tabetic bladder, for example, it is important. After the supra-pubic operation—when more or less ammoniacal decomposition has occurred—I think

the bladder should be irrigated; nevertheless, I think one can safely say that the bladder may be unnecessarily meddled with by the acceptance of a routine of procedure without regard to the peculiar necessities of the case.

Dr. A. Newman: I shall have to confine my remarks to the rectal part of Dr. Sherman's operation. I want to congratulate Dr. Sherman on this case; it is not often that we get carcinoma of the rectum we definitely cure. Unfortunately most carcinomas of the rectum that come to us have lasted too long and the patients are too far gone. Cripps says that out of 380 cases he was only able to do the radical operation on a little more than 20%.

A patient I did a colostomy on recently, showed blood for two years and waited until the entire sphincter was destroyed and the process had extended on to the buttocks before he came for examination. All the cases we get in the City and County Hospital are too far gone for anything but a palliative operation. Dr. Sherman was fortunate in having this patient sent to him in time. In his case he has also preserved the sphincteric integrity of the patient, which is a very good thing. There is nothing more pitiable than a patient cured of his disease, but left miserable for the rest of his life.

Dr. C. G. Levison: Where did you do your colostomy?

Dr. Sherman: A left inguinal colostomy.

Dr. Levison: Did it heal spontaneously?

Dr. Sherman: No. I closed it. The technic of making the colostomy was that of Ward, as given by Moynihan. The spur formation was very satisfactory and delivered all the feces on the surface.

Dr. S. Beasley: Was a histological examination made of the tissue removed?

Dr. Sherman: The rectal tumor, histologically, was an ordinary cylindroma of the rectum, and fortunately, scirrhous.

Dr. C. G. Levison: The question as to whether a preliminary colostomy should be made in the treatment of cancer of the rectum, has never been decided; some operators believe that a colostomy should always be done prior to operation. If there is no bowel obstruction I do not feel that this is necessary. I have described a method in the "Military Surgeon," May, 1912, which is at times very serviceable, more particularly when a colostomy of the small intestine is necessary. Frequently the colostomy does not have a spur sufficiently prominent and as a consequence feces will escape into the rectum so that it is important in cutting off the protruding intestine that the lower end should be more prominent than the proximal end. This is a point that is not generally emphasized in the operation. Another factor in connection with the control of the colostomy is its situation. If a loop of the colon is drawn out through an opening made in the loin a pad can be easily applied over the opening and it can be maintained in position by a belt. This is not possible if the colostomy is made lower down in the inguinal region as it is usually done. The loin or waist line permits the belt to slip into position and it remains here. In this way a colostomy well performed through a muscle splitting operation keeps contamination at a minimum. It is important that a part of the colon should be drawn up into the wound, allowing the slack of colon lower than the colostomy opening; this gives a reservoir effect. The patient has one or two bowel movements a day and the remainder of the time his artificial anus is clean.

A point or two in connection with the diagnosis of carcinoma of the prostate might not be malapropos. In a recent conversation with Dr. Young of Baltimore I elicited from him why he performs the perineal operation in preference to the supra-pubic operation. He stated that as far as the mortality was concerned he performed the perineal operation not because it offered a lower mortality

than the supra-pubic but because it was possible to recognize a carcinoma of the prostate much earlier than is possible by the supra-pubic operation.

He stated that in his experience, which Judd of Rochester confirms, 20% of the prostates are carcinomatous. As carcinoma of the prostate commences in the posterior capsule, which is allowed to remain in the supra-pubic operation; by means of the perineal operation he can recognize this condition earlier, at a time when it can be removed, satisfactorily.

I had the fortunate experience while in Baltimore to see this idea carried out. The patient was being operated by Young for an enlarged prostate; he recognized a nodule in the posterior part of the prostate which he had excised and examined microscopically; the report was returned of carcinoma and Young removed the prostate and bladder according to his published methods. The operation impressed me as being exceedingly difficult and it was performed by him in the most skillful manner.

The one point above all that he observed was absolute hemostasis. He removed the prostatic urethra, bladder and prostate up to the trigone. He then closed the bladder which he anastomosed to the membranous urethra.

Dr. Sherman, closing discussion: The patient to whom Dr. Krotoszyner referred I have not included in this list because he had to be turned out of the hospital for insubordination, and the final result was never known. The man had been kept in the hospital for some time before the operation for observation by Dr. Moffitt. The prostate slipped out with remarkable ease, and was not carcinomatous.

As regards the washing of the bladder, the bladder is lined with squamous epithelium, and is merely to contain urine. That kind of a mucous membrane is very resistant to infections, and if drainage is properly arranged for a post-operative infection of the bladder is most unlikely, or, if there is a pre-existing infection it is likely to subside. Washing is superfluous and may implant fresh infection, and so is potentially mischievous. As regards the vesical sphincter, the patient can stop voluntarily the stream when in the act of urinating, but he dribbles a little in the afternoon when he is tired and is on his feet. The competence of the rectal sphincter I think Dr. Krotoszyner could feel when he passed his finger into the rectum.

#### A CASE OF LUDWIG'S ANGINA.

K. B. Aetat 45. For twelve days before admission to St. Luke's Hospital in 1911 the patient had a sore throat and painful deglutition. At first he continued at work; later he had to stop, and still later he had to come to the hospital because he became quite unable to swallow. Speech was difficult, and dyspnea came on.

On admission his neck was swollen, more on the left side, where the swelling extended from close to the jaw quite down to the sternum. The surface was not discolored, was firm and smooth, and no evidence of fluctuation could be detected. It was not possible to examine his throat, but his tongue was not swollen.

After admission the dyspnea increased, and so I incised the swollen neck. As the swelling reached down to the sternum I made a transverse collar incision just above the manubrium and clavicles, going through the deep fascia and then opening up areolar planes by hemostat dissection, but no pus was found. A second incision was made at the level of the crico-thyroid membrane to look again for pus and, if none was found, to permit a laryngotomy. Fortunately pus was found beneath the left sterno-mastoid; it was foul smelling, as if the bacillus coli communis was present, but the hospital record contains no mention of an

examination. The abscess was tube-drained, and the wounds were both packed. There was an immediate alleviation of the symptoms, but the implication of the pharyngeal muscles and the palate was shown by regurgitation when attempts were made to swallow. Improvement was interrupted on the third day by discharge of blood-streaked pus from the mouth, and on the seventh day the patient coughed up a slough from the throat and one also was removed from the wound in the neck. On this day he could swallow some solid food, and convalescence was then uninterrupted.

A late bacteriological examination showed the presence of the staphylococcus alone. No streptococci were found.

Ludwig's Angina is a condition in which I had become interested without seeing a case of it, and this patient came to supply the needed example. It is a diffuse cellulitis beneath the deep cervical fascia, due in most instances to the streptococcus, but it may be caused by the pneumococcus or the staphylococcus, or a complex kind of mixed infection. The infection atrium is by a carious tooth, or the middle ear or by the tonsil, and the first site of the cellulitis may be in the sublingual space in the floor of the mouth—a sublingual phlegmon—or, more commonly, the first lesion may be a submaxillary bubo in the lymph glands around the sub-maxillary salivary gland. From the sublingual phlegmon, the infection may spread back and down the pharynx, and also into the neck by the space between the posterior edge of the mylohyoid and the middle constrictor of the pharynx. Or from the sub-maxillary bubo the infection may enter the mouth by this same space, and then extend down the pharynx. The infection does not travel by the lymph channels, but by continuity of tissue, and it travels rapidly.

The infection does not at once produce a reaction in the shape of pus, but may be too virulent and too rapid, and so result in calling out only a serous exudate, while the areolar tissue and sometimes the muscles become gangrenous. If the patient lives pus is produced and accumulates under the tongue and beneath the deep cervical fascia. Externally a woody induration is produced with much swelling, so that the tissues of the neck fill up the space quite level from the point of the jaw to the chest, and this may be on one side or on both sides, the condition extending around beneath the mandible from one side to the other. The skin of the neck is usually not reddened, but is tense over the underlying tissues. If the process has begun in the neck the course is longer and not particularly dangerous until the sublingual tissues are affected; then the tongue is lifted and pressed against the roof of the mouth, and it also swells; and so, as the mandible cannot be depressed because of swollen neck, the patient can neither speak nor swallow, while profuse salivation adds to the distress. From the sublingual location the infection spreads down the pharynx, causing edema of larynx or septic pneumonia. If the process begins in the mouth, this end is more quickly reached. As this is a deeply situated lesion, openings do not occur on the surface, but do occur in the pharynx, and so infection may reach the larynx without having passed through the mouth; or, beginning in the neck, and failing to open and discharge into



the mouth or pharynx, the cellulitis may extend into the mediastinum and so cause a septic pneumonia. The effect on the patient is that of a virulent septic infection, plus the interference with the function of the parts involved,—speech, deglutition, respiration—plus, also, the infection of larynx and lungs. Death may come in a few hours from overwhelming sepsis, or later from interference with nutrition and more particularly respiration (edema glottidis), or later yet from septic pneumonia, and it may even occur when the patient is seemingly convalescent, and then is apparently by heart failure.

In Thomas's careful paper (An. Surg., 1908, p. 169), he reports 106 cases, observed or collected; in ninety-two the swelling began external to the mouth and pharynx, and in sixty-one of them it was first noticed in the sub-maxillary region.

Incision in this region, parallel to the border of the mandible, is of prime importance, though a mesial incision from the jaw to the hyoid quite through into the mouth has been advised and practised. The incision must go through the deep fascia or to pus. If it is made early only serum may be found, and gangrenous cellular tissue.

After the supervention of edema of the larynx, tracheotomy will be of very doubtful value, as the trachea would be opened directly into an infected area.

There has been much discussion regarding the keeping of the name "Ludwig's Angina." In 1895 Felix Simon, St. Thomas, London, claimed that acute edema of the larynx—edematous laryngitis—erysipelas of pharynx and larynx—phlegmon of pharynx and larynx and angina ludovici, were all the same thing. This seems to me to be too sweeping a statement, for laryngeal and pharyngeal infection may occur without the cellulitis, or cellulitis may not lead to the infection of the larynx and pharynx.

Thomas advises the keeping of the name, as indicating a fairly well defined lesion, which is said to be not so rare as my experience would make it.

#### THE EPIDEMIOLOGY AND CONTROL OF RABIES.\*

By W. A. SAWYER, M. D.,  
Director of the Hygienic Laboratory of the California  
State Board of Health.

Rabies is a serious and expensive disease which can easily be prevented by the communities involved. A knowledge of its epidemiology is the only reasonable basis for determining the necessary preventive measures.

Epidemics of rabies display certain features which are explained by the characteristics the disease shows in the individual case. For one thing, there are no prolonged cases or chronic carriers to harbor and spread the disease over long periods of time, as rabies is almost invariably fatal after an illness of from two to ten days, usually

five or six. The diseased animal as a rule spreads the infection only during the few days of evident symptoms, although there is a possibility of transmitting the disease from two to eight days earlier. From this it would appear that an epidemic could be promptly and effectively suppressed if the acute cases could be controlled over a period of a very few weeks. This would be true if it were not for another striking characteristic of rabies—its long incubation period. An interval of complete absence of symptoms occurs between the inoculation and the appearance of the disease. This interval is seldom less than two weeks, usually from one to three months, and in rare instances six months or over. The long incubation period separates succeeding generations of the disease, leading the public to feel that the outbreak is confined to the few early cases, when in reality the disease may be slumbering and preparing to break out in a formidable epidemic.

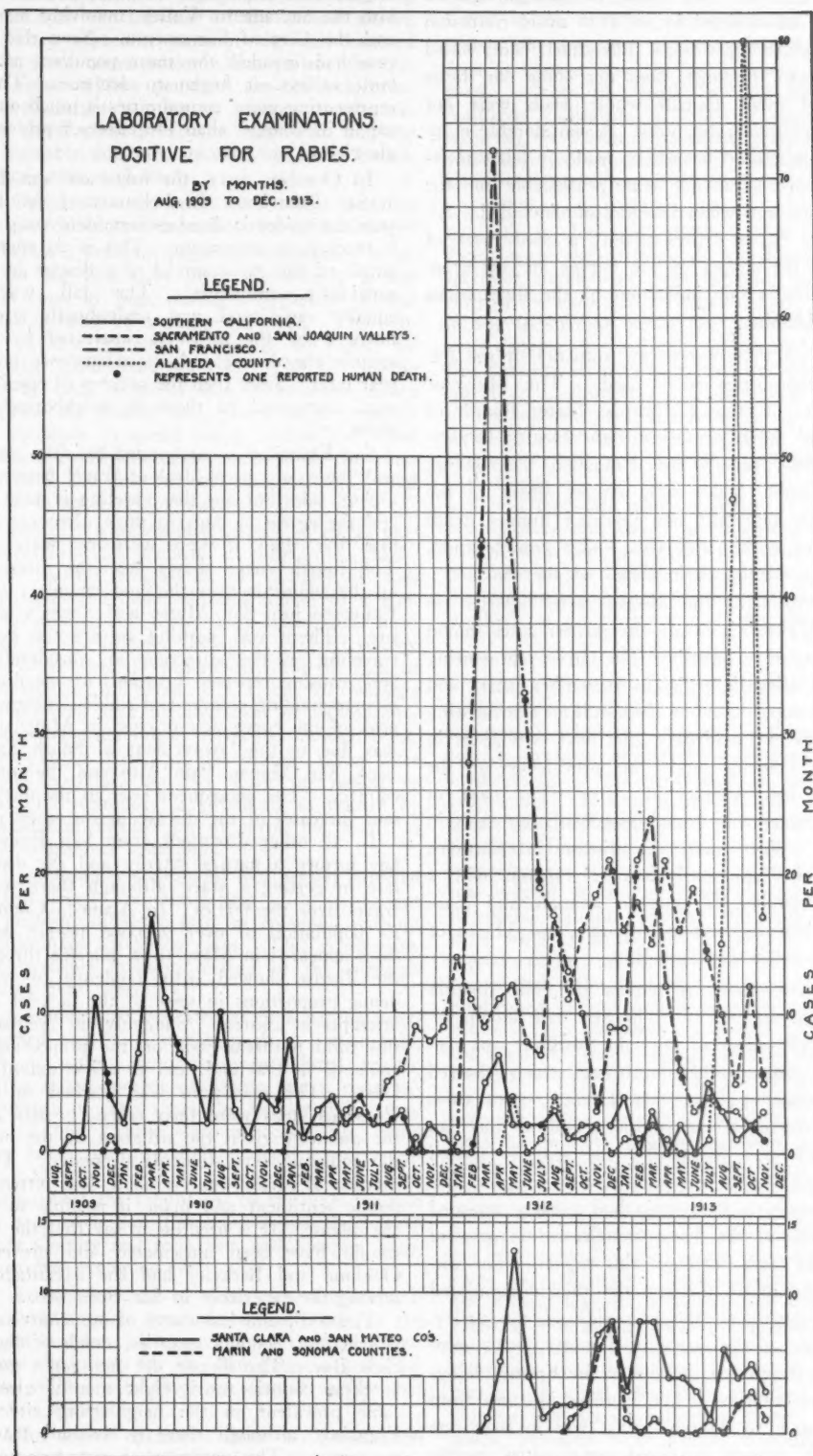
The third important characteristic of rabies from the standpoint of epidemiology is its transmission only through inoculation, and almost entirely through the bites of the diseased animals. This means that the disease can be absolutely interrupted in a period of time determined by the incubation period, if the infected animals can be prevented from biting. The method of transmission of the disease would not explain its perpetuation and extensive distribution if a tendency to snap and bite were not an early prominent symptom in many of the canine cases.

These three characteristics of rabies—the long incubation period, the short period of infectivity terminated by death, and the transmission by bites only—permit a rough prediction of the course of an epidemic and the formation of a reasonable plan for the control of the outbreak. A more accurate prediction, however, can be based on the study of previous epidemics as a whole.

In California we are having an unusual opportunity for studying the epidemiology of rabies. The disease a few years ago made its first entrance into the state, and it has appeared in one community after another, showing its manner of invasion and development in previously uninvaded fields. The courses of these initial epidemics show certain characteristics which permit of generalization and are therefore worthy of special attention.

In the accompanying chart the incidence of cases by months has been shown for several important divisions of California. The curves represent laboratory examinations of the heads of animals with resulting positive diagnoses of rabies. The curves show only a small part of the total

\* Read before the San Francisco County Medical Society, December 2, 1913.



number of cases in the state. Certain portions of California are omitted in order to avoid confusion from too much repetition. The chart, being based on laboratory findings, does not show the large number of rabid animals whose heads were not sent for laboratory diagnosis. A considerable number of examinations have been made by laboratories whose reports were not readily available for the entire period and were therefore not included. Although the curves represent only a small part of the cases, the shapes of the curves are nevertheless probably a fair indication of the fluctuations of the epidemics.

In making these curves the statistics of the following laboratories were used: The Hygienic Laboratory of the California State Board of Health and the laboratories of the Health Departments of Los Angeles, San Francisco, Sacramento, and Oakland. Small solid circles added to the curves each represent one reported human death from rabies within the area under consideration, and during the month indicated on the chart.

A few cases of the disease were reported in Southern California before the earliest dates shown by the laboratory records. The curve representing Southern California begins in September, 1909, and shows a sharp rise in November, representing chiefly cases in Pasadena. The next two peaks in the curve coincide with the prevalence of the disease in Los Angeles in 1910. The peak in January, 1911, was caused principally by cases in Riverside. Since then the disease in Southern California has apparently become endemic, with a decreased number of cases in animals and man. The moderate increase in February and March of 1912 occurred in Los Angeles.

The second curve represents the San Joaquin and Sacramento valleys. The first case shown occurred in December of 1909 in Stockton and represents a circumscribed outbreak which showed little tendency to spread. In January, 1911, cases were discovered in the southern end of the San Joaquin Valley. Apparently the sparsely settled mountainous region between the San Joaquin Valley and Southern California had greatly retarded the extension of the disease northward in spite of the railroad traffic through this region. The disease spread rapidly through the thickly populated farming country on the east side of the valley. The summit of the curve in January, 1912, represents the height of the disease in Fresno, Kings and Tulare counties. The increase in cases from August, 1912, to March, 1913, was in part due to cases in recently involved communities in the northern end of the San Joaquin Valley, but

largely to the passage of the epidemic northward into the Sacramento Valley, involving many towns and the City of Sacramento. Now that the disease had invaded the most populous portions of both valleys, it began to decrease. This curve representing many communities is much more gradual in its changes than the curves representing single cities.

In October, 1911, the first case was discovered in San Francisco. In February of the following year the epidemic developed suddenly and in April it reached its maximum. This is an excellent example of the rapid spread of a disease in a region previously uninvolved. The fall was almost equally rapid and was undoubtedly greatly influenced by the measures instituted by the city against the disease. A recrudescence occurred a year later. Since then the number of cases has been small compared to those in neighboring communities.

San Francisco is surrounded by cities and towns, and there is a great deal of travel between them. On all sides but one the traveling is done by ferry and the egress of dogs in these directions is therefore less than if there were no water barrier. The fourth curve shows how the disease spread up the peninsula over the land boundary from San Francisco into San Mateo and Santa Clara counties. There was nothing to prevent dogs from traveling in this direction in considerable numbers, causing repeated invasions of the disease and a correspondingly early and sudden epidemic. The peak of the curve was reached in May, 1912, and was due to the involvement of South San Francisco, San Mateo, Palo Alto and the intervening country. The subsequent rises in the curve represent increases of the disease in the same region.

In all other directions from San Francisco the bay formed a natural barrier and the disease was late in getting a start, although there was much travel over the ferries. In Alameda County, with its population of over 200,000 people, scattering cases appeared in May, 1912, but for three months the disease showed little tendency to reach epidemic proportions in spite of the lack of adequate attempts at control. Suddenly, in August, 1913, this mild outbreak took on the proportions of an epidemic in Oakland, and to a less extent in Berkeley. The maximum was reached in October. Vigorous steps were then taken, greatly aided by the publicity given the situation by the press, and the epidemic very suddenly decreased. The large number of persons and valuable dogs bitten aroused public sentiment and made it possible to suppress the disease. It is needless to say that the outbreak should have been anticipated and prevented, as Oakland and Berkeley had the advantage of observing the experience in San Francisco.

The sixth and last curve of our chart represents Marin and Sonoma counties, north of San Francisco Bay. The disease did not get a good start in these counties until eight months after it became prevalent in the neighboring city of San Francisco, although there is constant travel over the ferries. The maximum of cases was apparently reached in December, 1912.



The cases in human beings are coincident in each area with the presence of the disease among dogs. They represent part of the toll exacted by rabies from communities which permit the disease to exist. Other penalties are the subjection of a much larger number of persons to the expense of the Pasteur preventive treatment, and the loss of valuable domestic animals, including horses, cows, pigs, goats and dogs.

The California experience with rabies leads to several generalizations regarding its epidemiology:

1. When a separate populous community is invaded for the first time there are usually a few scattered cases in dogs, during a period of several months, followed by a sharp epidemic. The subsidence of this epidemic is apt to be rapid, although less rapid than the rise. The fall in the number of cases is partly due to measures taken to suppress the disease and partly to a tendency of the epidemic to spend itself. After the rapid fall, rabies usually becomes endemic in the community and the number of cases is small and fluctuates in an irregular way.

The manner in which an epidemic of rabies partially spends itself is a matter of conjecture. Probably this natural decrease in the number of cases depends upon the death through rabies of a considerable number of those dogs which are most likely to become infected owing to unusual susceptibility, or to special vulnerability due to lack of skill in fighting or short hair, habits of roaming the streets, and lack of discretion in approaching and attacking other dogs. Acquired immunity can scarcely play a part, as the disease when once developed is fatal, and we have no reason to suppose that immunity is produced in nature by rare accidental inoculation of virus too small in amount to produce symptoms.

2. A community contiguous to a heavily infected area, and freely communicating with it, is apt to be plunged suddenly into an epidemic without the preliminary scattering cases. This is probably due to multiple invasion instead of the entrance of a very few cases.

3. A community separated from a nearby heavily infected area by a barrier, such as a mountain, a body of water, or a thinly populated region, even if a large number of people and a considerable number of dogs cross the barrier daily, may escape all but a few scattered cases for many months, but is apt ultimately to have a severe epidemic. The spread of the disease from Southern California over the mountains to the San Joaquin Valley and from San Francisco across the bay to Alameda County and to Marin and Sonoma counties furnishes examples.

4. Areas made up of many separate communities show a more gradual rise and fall in the aggregate number of cases than do single cities. Compare the curves for the San Joaquin and Sacramento valleys with those for San Francisco and Alameda County.

5. The severe epidemics show no predilection for hot and dry months, nor for any particular season. In fact, the Los Angeles and San Fran-

cisco outbreaks reached their maxima in March, a cool season with abundant moisture.

6. The presence of an epidemic of rabies in dogs is almost sure to result in a few human deaths. Note the deaths in San Francisco and Southern California in spite of opportunity for receiving the Pasteur treatment, privately, or without charge from the state. It is impossible to bring all persons bitten under treatment.

7. The spread of an epidemic of rabies in new territory is slow and steady, as if the principal factor were the carrying of the disease by a considerable number of dogs traveling out from the edge of the involved territory on foot. While dogs in the incubation period are taken at times over long distances by railroad, or automobile, or boat, this does not seem to have been the chief method of spread in California. The more dogs passing out of the infected area, the better is the chance that some of them will be in the acute or incubation stages of rabies and that part of these will have the disease in the more dangerous furious type and will inoculate many animals. That the progress is slow and steady is illustrated by the fact that it took over a century for rabies to cross the continent to the Pacific Coast, and over three years for the steady march of the epidemic from the southern to the northern end of California.

#### CONTROL.

If the California epidemic of rabies was so steady in its spread that each community could anticipate its arrival, why were not the well-known and effective measures of control applied to prevent the involvement of the great central valleys and the large cities? It is true that the course of the epidemic was well known and was freely predicted by the State Board of Health, and advice was given regarding the best methods of control. While this was helpful in keeping down the number of cases in special communities, the effect on the situation as a whole was slight. It takes so long to get special action against disease in our American towns and cities that the disease usually becomes established before action is taken, and the epidemic is only palliated, not prevented. Then, too, the measures are usually applied in a half-hearted, ineffective manner which keeps down the number of cases without stopping the outbreak. The more successful the control the less apparent is the need for it, and as public support lessens the action of the authorities becomes more difficult and less effective. The usual experience in California was, therefore, no action until the disease appeared, much discussion and half-hearted action during the critical period when the early scattered cases were discovered, fairly effective control when the disease was at its height, and a relaxation of effort as soon as the epidemic had diminished. Under even these circumstances the results would have been much better had it not been for two factors which acted specially to prevent the eradication of the disease in communities. In the first place, measures were usually discontinued in less than six months after the last known case, usually within a few weeks. This was due to a failure

of the authorities and the public to appreciate the full significance of the long incubation period.

The second of these important factors is that the attempts at control involved areas so small that even complete eradication of the disease would be followed by reinvasion from the surrounding country. To overcome this difficulty the State Legislature in 1913 enacted a law putting the direction of the control of rabies under the State Board of Health and compelling local authorities to carry out the provisions of the act. As rabies is a disease of large areas it should be fought by concerted action under the direction of a central authority.

The methods of control which have been found efficient are essentially as follows, and will be found embodied in the regulations of the State Board of Health:

1. All cases of rabies should be promptly reported to the local health authority for investigation and action.

2. Animals under suspicion of having rabies and all dogs which bite human beings should be taken up and confined separately under observation for a minimum period of ten days. These animals should not be left at their homes as they often bite the people who care for them, and not infrequently escape.

3. Dogs which have been bitten by rabid animals should be killed if their value is not sufficient to warrant their being immunized. Confining such animals under observation for two or three weeks does not give protection, as the incubation period is usually longer than that and is often several months in duration.

4. When persons have been bitten by rabid animals the wounds should be cauterized at once, preferably with nitric acid. Then the animal should be captured and kept under observation for ten days. It is not good advice to recommend the killing of the dog so that its brain can be examined. If the dog is killed and the microscopical examination is negative, the diagnosis is still in doubt. On the other hand, if the dog is kept alive a provisional diagnosis can usually be made within twenty-four or forty-eight hours, and if the animal remains well for ten days, rabies is disproved.

5. If a dog which has bitten a person has been killed or has died under observation, the head should be removed and sent to a municipal or state laboratory for examination. The Hygienic Laboratory of the California State Board of Health from the beginning of the epidemic in 1909 up to December 1, 1913, made 758 examinations for rabies with positive results in 613 cases.

6. If a person has been bitten by a rabid animal so that the skin is broken, or if the saliva of a rabid animal has entered a fresh break in the skin, the Pasteur preventive treatment should be administered as soon as possible. Provision for this has been made in California by the State Board of Health, which administers the treatment free at eight laboratories. This treatment is available to persons who are unable to pay the cost of antirabic

treatment without undue hardship and who bring the recommendation of the local health officer. Persons who are able to pay for the treatment are expected to procure it from their physicians, who can purchase the virus from commercial biological laboratories. The State Hygienic Laboratory has manufactured and administered treatment to 322 persons in the seventeen months preceding December 1, 1913, and previous to that time it administered virus from the Hygienic Laboratory at Washington, D. C., to 103 persons. The Cutter Laboratory kindly furnished us the information that they had sold treatment for 207 persons in California during the twelve and one-half months before December 1, 1913. When we consider that other firms are selling virus in California, we can see that the number of persons bitten by animals known to have rabies, or suspected of it, has been large. This indicates the necessity for adequate measures against the disease.

7. On the first appearance of rabies in a community measures should be instituted to protect the public and to eradicate the disease. These should include the destruction of all ownerless dogs, diminution in the number of dogs through a license tax, the muzzling of all dogs free on the streets, adequate facilities for taking up, impounding, isolating, observing and destroying dogs, investigation of all reported cases by someone competent to give advice regarding treatment and the destruction of animals which have been bitten, arrangement through the State Board of Health for the institution of measures in neighboring areas, and, if necessary, quarantine against dogs.

In closing, I wish to protest against the shooting of dogs on the street, except in emergencies where there is an actual and immediate danger. With suitable provisions for a pound, dog-catchers and wagons, there is no need for noise and disorder and bloodshed in the suppression of rabies.

In all cases the measures should be based upon a thorough knowledge of rabies and its epidemiology, and special pains should be taken to spread such knowledge among the general public.

#### A POSITIVE READING MANOMETER FOR THERAPEUTIC PNEUMOTHORAX.

By EDWARD VON ADELUNG, M. D., Oakland.

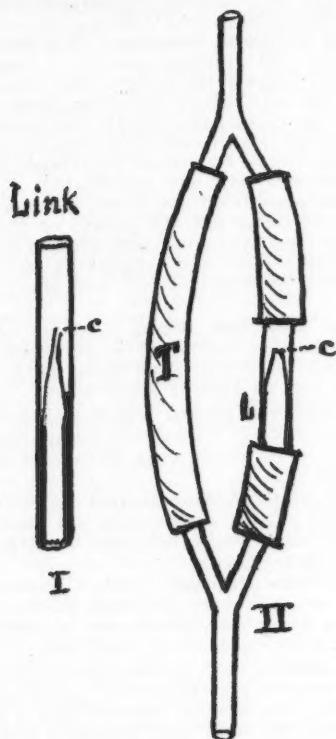
Artificial, or therapeutic, pneumothorax cannot be safely done without careful guidance by the manometer. The reading of this gauge is of prime importance. As is well known, the fluid in the manometer is in constant motion because the intrathoracic pressure is constantly changing, due to the patient's breathing. Some operators record maximum readings, and some record minimum readings. Both of these figures vary more than the figure that represents the *mean* pressure. I am therefore here advocating the recording of *mean* pressures as more accurate.

I wish to call attention to a simple attachment for the manometer, attachable to any form of manometer. Its use secures a non-oscillating mean pressure registration.

The device is shown in Figure 1. A capillary

tube is fixed in a larger tube for protection, so that pressures must reach the manometer through the small opening *c* of the capillary tube. This link (or any device that forces registration through a minute aperture) is placed in one limb of the divided tube leading to the manometer as shown in Figure 2. By pinching off the rubber limb *T* all pressures are forced through the link *L*. When *T* is pinched off the manometer will register the mean pressure, either positive or negative, *unobscured by oscillations*.

The writer believes that the adoption of this device would render the records of all workers uniform in their meaning—something much desired.



One unfamiliar with this device might immediately object that it is very undesirable to do away with the oscillations because they are the very thing needed for safe work, inasmuch as free oscillations are the best indication that the needle is in the pleural space. The reply is that all that is necessary to be done to obtain this information is to leave *T* open, when the usual oscillations will occur. Thus both uses of the manometer are readily available.

This device offers the following advantages:

1. Ease of reading, oscillations being abolished.
2. Uniformity of records, mean pressures only being recorded.
3. Protection of manometer against overflow when patient coughs or strains.
4. Greater accuracy, inasmuch as the mean pressure varies less than either maximum or minimum pressure.
5. Simplicity.

## LOS ANGELES COUNTY MEDICAL ASSOCIATION.

### Annual Report for the Fiscal Year Ending December 18, 1913.

To the Members of the Los Angeles County Medical Association:

Your Secretary-Treasurer begs leave to submit the following report for the forty-third year of the association, ending December 18, 1913:

#### PART I.—REPORT OF THE TREASURER.—FINANCIAL REPORT.

The financial report of the association for the period, December 19, 1912, to December 18, 1913 (with the cancelled check stubs, receipted bills and ledgers, for the inspection of the auditing committee), is as follows:

##### A.—Maintenance Income of 1913.

Total first half year dues.....	\$3672.00
Total second half year dues.....	3636.00
Special assessments .....	1779.00
Miscellaneous .....	11.00

Total all income, 1913.....	\$9098.00
Carried over from 1912.....	156.61

Grand total all income during 1913.....\$9254.61

##### B.—Maintenance Expenses of 1913.

1. Paid assessments to State Society.....	\$2508.00
2. Envelopes and postage.....	331.16
3. Printing bills .....	1070.90
4. Hall rent .....	145.00
5. Refreshments at regular meetings.....	474.26
6. Clerical expenses .....	766.94
7. Miscellaneous .....	33.95
8. Telephone exchange .....	482.19
9. Prosecution of Illegal Practitioners.....	1186.94
10. Special expenses .....	1319.94

##### Special Expenses Subdivided.

a. Annual meeting banquet.....	\$ 461.17
b. Christmas jinks (music, costumes, etc.) .....	320.17
c. Tellers .....	15.00
d. A. M. A. Journal subscriptions for newspapers .....	30.00
e. Stereopticon: Dr. Murphy's address .....	6.00
f. Ear, Nose and Throat Section annual allowance .....	43.00
g. 12 copies of "Nostrums and Quackery" .....	10.40
h. Collection books .....	341.90
i. Postage on collection outfits.....	24.40
j. Film to illustrate Dr. Tait's address .....	2.90
k. Annual allowance, Pasadena Branch .....	65.00
l. (Prescription blank outfits will be charged against next year's budget.) .....	
	\$1319.94

Grand total all expenses during 1913 was \$8319.28  
Summary, 1913.

Grand total income.....	9254.61
Grand total expenses.....	8319.28

Balance in treasury.....\$ 935.33  
PART II.—REPORT OF THE SECRETARY.—GENERAL REPORT ON THE STATE OF THE ASSOCIATION.

The year 1913 may be said to show a continuation of the progress which has marked the career of our Society in recent years.

1. **Membership.** The total number of members



for whom we paid assessments to the California State Society was 622. The figures show that the Los Angeles Society has doubled its membership in the last eight years. Our Society continues in 1913 as the largest county medical unit in the State of California.

While the number of men who have been dropped for non-payment of dues is larger than we would wish, the number is, after all, by no means to be construed as excessive. There have also been a number of losses through transfers, resignations and deaths.

It was thought in 1910, immediately after the A. M. A. meeting, there would be a big loss in our membership, because it was believed that many new members entered at that time simply to participate in the A. M. A. Los Angeles meeting festivities.

Time has shown that this was an error, and that the members whom we have enrolled in recent years, have largely been of a permanent character.

It is not to be wondered at, if in an organization of over 600 members, that there should be a loss every year of a certain number of members, because this is the experience of almost all kinds of social and other organizations.

Nor is it to be wondered at that a number of men neglect to keep up their financial obligations to the Society, as is evidenced by reference to the bulletin boards of social clubs, where a large number of names are almost constantly posted for non-payment of dues, etc.

In view of the tremendous advantages, which accrue to every man who is a member of our Society, there is little reason for withdrawal simply from the standpoint of dues.

And to-day, under the rules of the Society whereby a member automatically cuts himself off from membership through non-payment of dues, we are in a far better condition than we were ten years ago when the dues were considerably less; but when even well-to-do members would permit their dues to become delinquent for five or six years; and at which time it was necessary also to usually send out a lay collector at the end of each year, at a cost of 25 to 50 per cent. commission, to try to collect delinquent dues. Certainly no man is entitled to the large number of benefits such as accrue from membership in our County and State Societies, unless he is willing to pay his just pro rata of the expenses of the upkeep of those organizations, which exist, not only for the sake of maintaining scientific societies, but for the purpose of having organizations of high standards and ideals to protect our individual professional interests.

**2. New Members for 1914.** Some time in January, there will be mailed to every member an application blank, and it is hoped that all will respond to the request that an effort be made to place these blanks in the hands of fellow practitioners, whose training and professional careers give indication that they would make desirable members in the Los Angeles County Medical Association.

The advantages of membership, as enumerated below, should give all members sufficient argument and reasons for asking any desirable practitioner to put in his application to our Society.

In calling the attention of such prospective members to the advantages of membership, the following advantages, which all fair-minded persons must agree are far more than an adequate return for the \$15.00 annual dues, may be kept in mind.

#### 1. Society Membership Advantages.

The annual dues give membership in:

**A. The Los Angeles County Medical Association.** (This Association holds two meetings every month,

excepting during the summer months. The scientific papers and the informal luncheons at the end of the meetings, afford splendid opportunity for the development of professional and fraternal features.)

**B. Medical Society of the State of California.**

**C. Eligibility to membership in the American Medical Association.**

Note: No doctor can become a member of the A. M. A. who is not a member of his State Society.

#### 2. Material or Money Advantage Returns.

**A. Malpractice Defense.** (Through the State Society, every member of the County Medical Association, who pays his dues promptly, is defended from malpractice suits, and is given as efficient defense as can be purchased through a private policy in a private company for \$15.00.)

**B. The Telephone Exchange.** (The members of the Society will gradually appreciate that this is one of the biggest things that the Los Angeles County Medical Society has ever done—and its value to the community and to the members of the ethical profession cannot, in fact, be estimated—but there will be far greater advantages than 80% of the members even now appreciate.)

This exchange is open day and night, and without charge, will permit any patient or any doctor to get into communication with any physician who is a member of the Los Angeles County Medical Society at a minimum of time and effort. Use it freely.

**C. The Collection Bureau. Outfits.** (Similar outfits cannot be purchased in the open market for less than \$3.00 a set, and many outfits far less desirable, cost as high as \$10.00 a set.)

**D. Prescription Blanks.** (That seal leather case and the prescription blanks with carbon pages, cannot be purchased in the open market for less than about \$3.00.)

**E. The State Medical Journal.** (This Journal presents all of the papers that are read at the State Society meetings, and gives the news of the California profession.)

**F. The State Register.** (This register has the name of every licensed physician in the State of California, and places the names of members of the County Society in black faced type.)

**G.** In addition, each member receives the **County Bulletin** which keeps the men in touch with what is going on locally; and there is usually some of the standard literature like "Nostrums and Quackery," etc., which is published by the American Medical Association.

Leaving out of all account the great value that comes from affiliation and membership in a recognized society of ethical practitioners and the pleasure that comes to every man who wishes to do his individual part in the collective development of his group, there are then these dollar and cent advantages, which can easily come up to a total of \$40.00. If there is any man in the Society who can show a single other organization which, for the dues which he pays, gives him as many compensatory returns as the \$15.00 dues of the Los Angeles County Medical Association, that man is certainly to be congratulated.

Members should not, therefore, feel any hesitancy at all in asking prospective men to make their applications for membership.

Our Society should work constantly toward the goal of having enrolled in its membership every desirable practitioner of medicine in Los Angeles County. Every such practitioner is wanted and needed, but all who are not desirable, should be severely left alone. The Society cannot profit to

any material extent by taking into its corporate body those who can neither appreciate the advantages of membership or the ethical principles and spirit that have inspired the formation of county medical societies throughout the United States.

**3. Scientific Meetings.** Our scientific meetings during the last year have measured up to the standards of previous years, though the secretary will not discuss whether or not those standards are as yet idealistic. The point is, that if there are any members in the Los Angeles County Medical Association who can present better papers, or could help improve the character of the scientific papers, then the fault for nonpresentation of such papers must rest, not upon our Society, but upon such individual members; for a general, as well as specific invitations, have been extended again and again to all members of the Society to give full co-operation in the matter of scientific programs.

Your secretary, among his other duties, has charge of the program, and he wishes publicly to thank the members who have kindly co-operated in the presentation of papers and clinical reports.

During the coming year it is the intention to vary the type of meetings somewhat by having at the Los Angeles County Hospital, a meeting about once every two months, when patients and specimens can be presented.

In this connection, an earnest plea is made to all members to lend more co-operation in the future than in the past, by presenting case reports, or specimens, or patients, at our regular meetings.

**4. Branches.** Among our geographical branches, the Pasadena Branch continues to hold first place. Our colleagues in Pasadena seem to have solved, with a certain degree of success, the matter of close union of all the desirable practitioners in that community.

Their branch continues to hold scientific meetings of value and interest, and they seem to have a local "get-together" feeling, that works well for the benefit and advancement of the entire Pasadena profession, and of that of surrounding towns.

Our Pomona Branch, though smaller, likewise continues to do very efficient service, and the programs which that branch has presented to our Los Angeles City Branch from time to time, are sufficient indication of the activity and capacity of our members who live in the Pomona Valley.

Our Santa Monica Bay Branch moves steadily forward, although it is handicapped somewhat by having a fewer number of members to draw upon, who live scattered about.

In Long Beach, a city of about the same size as Pasadena, our branch for some reason or other, seems to lack the snap which characterizes our colleagues in the foothills. It is hoped that during the coming year our members at Long Beach will again align themselves together in solid phalanx and take up again the work of organized medicine as a branch of the Los Angeles County Medical Association, in real earnest.

Concerning new branches, it was hoped that such an organization might perhaps be formed with the city of Monrovia as its center, but the time does not seem ripe for this.

**5. Collection Bureau Outfits and Book on Collections.** A complete outfit of our gummed collection slips and insert blanks, was mailed to all members during the year 1913, and the Society also purchased and sent to every member, a copy of Mr. White's Collection Book, in the belief that these books, while not necessarily of value to every member, would be of suggestive value, and would be worth the money expended, and of value to the majority of the members of our Association.

**6. Copies of the "A. M. A. Journal" to the Newspapers.** A matter of minor expense, and yet one not without some value and importance, we hope, was the sending, by our County Society, to the six daily newspapers of Los Angeles City, of current subscriptions to the "Journal of the American Medical Association."

We all must acknowledge that the newspapers only too often present faulty and distorted reports of medical topics. It was believed that the "Journal of the American Medical Association" in the libraries of these papers, would be an aid to the more intelligent conception of the purposes of organized medicine, and to that extent would be of benefit.

**7. Constitution and By-Laws.** Among other data sent out were copies of the Constitution and By-Laws of the Society. This new edition was printed so that all members might familiarize themselves with the rules and regulations of the Society. This Constitution and By-Laws was modeled after that of the A. M. A., when it was organized years ago, and whatever defects it may have, it must be acknowledged that with our own County Society, as with the State Association, and the A. M. A., the progress during these later years since the reorganization, has certainly been immeasurably greater than under the old loose system of organization which existed in previous years.

**8. Malpractice Defense by Our State Society.** Los Angeles County continues to be the cause of the greatest expense of any county to the State Association, as far as the defense of malpractice suits are concerned. Several of our local suits have cost the State Society over \$2000.00 each.

We do not believe that this larger proportion of suits in Los Angeles County is due to greater incompetency of the Los Angeles profession, because a study of the training and career of our members, shows that they measure above the average of practitioners of medicine. We must look upon these suits as an expression of fadism and antagonism, which exists to a greater or lesser degree through the ignorance and bias of medicine in the State of California. Because of the increased expense of these suits, it was necessary for the State Society to ask that \$2.00 more be given in the future than in the past into the State treasury.

It need only be repeated here, what has been so often stated in our Bulletin, that the State Society means to make absolutely reliable the State Malpractice Defense, and we of Los Angeles have certainly reason to take pride in this State Medical Defense and what has been accomplished.

**9. Prosecution of Illegal Practitioners.** During the last year our Society has spent over \$1200.00 to aid in the prosecution of illegal practitioners. This expense was incurred by the action of the Society itself at its regular meetings in a desire to help protect the public from unscrupulous and pseudo-practitioners of medicine and surgery.

The question has come up, however, and has been presented by a number of members of our Society, as to whether or not our organization, which is primarily a body organized for the development of scientific and professional standards, should go out of its way and become an active participant in doing work that belongs, not to us any more than to any other group of citizens of the commonwealth, but rather to the paid officials of the State, whose duty it is to look after all violators of the law of the State and of our cities.

On that account, it is quite probable, since the new State Board of Medical Examiners will be in a more independent financial condition than in the past, that during the coming year, our participa-

tion in the prosecution of illegal practitioners will take on a less active form.

**10. Our County Medical Association Telephone Exchange.** Quite the largest proposition that our Society inaugurated during the last year is our County Medical Exchange. The purposes of this Exchange and the work which it hopes to accomplish, and which we believe it will most splendidly carry out, have already been explained in some detail in the Bulletins of the Society. It is not necessary, therefore, to go over this subject again.

We believe that when we meet a year from now, that any who are skeptical concerning this proposition, will have been amply convinced of its exceeding great merit. Of course, there may be a few individuals who will find little use for this Exchange; but since it will help in the upbuilding of the professional interests of the great majority of the members, there is ample justification for its existence.

It is to be remembered that in this connection, as in all other things that are done for our Society, that not a single proposition can be brought forward that will benefit every member to exactly the same extent. All that can be done is to advocate and to inaugurate those measures which work for the upbuilding and betterment of interests for the majority of the members.

**11. Prescription Blank Outfits.** The last Bulletin contained a cut of the prescription blank form which is being printed, and an outfit of which will be sent to every member of the Society. If these prescription blank outfits did nothing more than relieve the members of our Association of the odium of using blanks with advertisements of drug stores, that in itself will be a great advance.

In addition, there is the additional good that will come from having virtually all of the members of our Society use prescription blank outfits arranged for carbon copies. We are all believers, we take it, in the efficiency of carbon copy blanks; and it is only through neglect, as a rule, that we fail to keep them up. These blanks will help all of us to be more exact in this respect.

The third great good that will come from these outfits, will be the education of the druggists and the public concerning our Telephone Exchange.

We are certain that when these outfits are received by members, that they will be the subject of real satisfaction and pleasure.

**12. Bulletins.** Little need be said concerning our County Society Bulletins. The effort has been made, as heretofore, to use the Bulletins as a means of keeping members of the Society in touch with one another's work.

We are too large an organization to ever get together, all of us, at one time, and some means of local intercommunication, such as the Bulletin, is necessary, if the members, who are widely scattered over this very large county of ours, are to be kept in sympathetic professional touch one with the other; and because of that need, we believe the publication of our Bulletins to have been justified.

**Conclusion.** In conclusion, your secretary-treasurer desires to thank all of the members of the Society for the co-operation that they have given him in his work.

It must not be thought the task of caring for the executive details of an organization having 600 widely scattered members, and with the large number of activities that our organization maintains, an insignificant one. The good that can be accomplished, through our collective efforts to strive for those things that make better the standards we all love, is sufficient compensation; and this is particularly so when one can appreciate that the

great mass of the members are willing to co-operate to the fullest possible extent within their power, in the work of increasing the power and influence of the Los Angeles County Medical Association.

We make our usual apology to any whose feelings we may have hurt. If any such instances have occurred, it was against our wish and desire. Your secretary-treasurer, therefore, thanks you all for your kind co-operation and willingness to aid him in his duties.

Respectfully submitted,

GEORGE H. KRESS,  
Secretary-Treasurer.

## PROCEEDINGS OF THE SAN FRANCISCO COUNTY MEDICAL SOCIETY.

### Section on Medicine, Tuesday, December 2, 1913.

1. The Epidemiology and Control of Rabies. W. A. Sawyer (by invitation).
2. The Diagnosis of Rabies in Animals. Karl F. Meyer (by invitation).
3. The Treatment of Rabies, Prophylactic and Curative. W. H. Kellogg. Discussed by R. G. Broderick, J. C. Geiger, G. H. Evans and J. Rosenstirn.

### ANNUAL MEETING.

Tuesday, December 9, 1913.

1. Remarks on Gastro-Intestinal Peristalsis, with Cinematographic Demonstration. Dudley Tait.
2. The Treatment of Typhoid Fever. William Fitch Cheney.

### Section on Surgery. Tuesday, December 16, 1913.

1. The Treatment of Flat Foot. A. L. Fisher. Discussed by L. Ely, J. T. Watkins, H. M. Sherman and E. Rixford.
2. Fractures Near to and Into Joints: II. Fractures Into Joints. Harry M. Sherman and Dudley Tait. Discussed by E. Rixford, A. Fisher and L. Ely.

### Section on Urology. Tuesday, December 30, 1913.

1. Cystoscopy as an Adjunct to Prostatectomy. G. L. Eaton. Discussed by R. L. Rigdon and V. G. Vecki.
2. Treatment of Gonorrhoea in the Female. John C. Spencer. Discussed by M. Krotoszyner, G. L. Eaton, V. G. Vecki and J. J. Hogan.
3. Does a Relationship Exist between Tuberculosis of the Epididymis and Tuberculosis of the Kidney? R. L. Rigdon. Discussed by M. Molony, M. Krotoszyner and G. L. Eaton.

## PRESIDENTIAL ADDRESS.

By H. B. A. KUGELER, M. D.

Fellow Members of the San Francisco County Medical Society:

I desire to thank the Board of Directors for the honor of electing me their presiding officer and President of the Society.

For eighteen years I have taken an active interest in the affairs of this Society, but even that did not bring to my personal knowledge the peculiar complaints of members and non-members as to what the Society should do and what it should not do. I desire to emphasize the fact that the most peculiar complaints came from those who were members and who never attended meetings. I have tried in every way possible to impress on the members that the only way that errors in the Society can be corrected is through the active participation of those members in the meetings and proceedings of the Society. To those members of



the profession outside of the Society, I have taken every possible occasion to bring home the fact that they could not dream of correcting errors in the Society unless they were members, and by their participation in the discussions and meetings correct any deficiencies that they felt the profession of San Francisco was suffering from.

I wish, furthermore, to express appreciation to the Board of Directors for their unfailing support and assistance in all acts that the President was called upon to do. I wish to thank the members of the Society for their uniform courtesy and their attention at the meetings. I must reiterate the statement that has been made for years, that the attendance at the meetings of the Society is to be deplored; the members should show a greater interest by being present.

When I was elected to the Presidency of the Society, there were three subjects that required immediate attention, as I said to the Board of Directors on assuming office.

The first was the question of membership. I felt that a more liberal interpretation of the requirements for membership should be impressed upon the Committee, particularly in regard to medical men who were doing contract practice. I was greatly supported in my attitude by the report of the Judicial Council of the American Medical Association at the last meeting of the House of Delegates, when the stand that I had taken was expressed in exactly the terms that I had felt as fundamental in this question.

The second subject was the amalgamation with a university library; and I feel that after many years of argument and discussion, this question has been settled once and for all. The County Medical Society must keep itself free from any entanglement with *any* university.

The third question was the proper housing of the Society. It has been understood for a number of years that the present housing of the Society was inadequate and a disgrace to a society of the size and standing of the San Francisco County Medical Society. After months of effort—years in fact—a plan was evolved which provided not alone for proper housing of the Society and its library, but at the same time provided a monument to the medical profession of the City and County of San Francisco. It is to be greatly deplored that there was not the co-operative spirit in the Society which allowed this plan to be matured. There is at the present time a plan in process of maturation which may provide the Society with a real home of its own, not entangled with elaborate financial possibilities. It is to be sincerely hoped that within a very short space of time this Society will have a decent home, where it can hold its meetings and where its members may not alone consult its library, but also meet on a social basis.

I would respectfully ask of the members of this Society their unqualified support of the State Board of Examiners. While it may be true that the law enacted by the last legislature is decidedly faulty, the present board is doing the very best it can.

It consists of men who are earnest in their endeavors to help the medical profession of the State of California, and I believe that they should have the absolute support of every reputable physician within the state.

For many years past it has apparently been the belief of the majority of members of the County Medical Society that it is the main function of that Society to act as a literary and debating society. This condition no longer obtains because a county medical society has a far larger function. It is at present the popular belief, not alone in the ordinary lay mind but even in the governing bodies of this state, that a county medical society is a branch of the so-called Medical Trust. It is unfortunately a fact that a medical society—or a Medical Trust, if it really exists—has not one iota of the power or cohesion that attaches to an ordinary labor union, and that charge must absolutely fall because it would be possible to get the members of no medical society to agree sufficiently to carry out any such motives as have been ascribed to us. It is true that there are a few counties in which the branch society has been able to bring into its fold every regular member and enforce certain fundamental things, but in any large city this has been impossible. The community at large must be taught to recognize the true status of its county medical society. It must learn to go to it for advice in medical matters, or matters pertaining to the public health, and also to heed the warnings of their local medical society when this society feels that such advice must be given. This fact has been impressed on the people of the United States in messages of former presidents and in planks of platforms by the leading political parties of this country. However, before we can expect the recognition of the community at large of the status which we are considering, it is necessary for us to do a very considerable housecleaning.

I would call your attention to the 14th verse of the 4th chapter of Jeremiah, where he says: "O Jerusalem, wash thine heart from wickedness, that thou mayest be saved. How long shall thy vain thoughts lodge within thee?"

I wish to call attention to a series of very serious abuses within the medical profession and suggest remedial measures for them. We will start at the head, or so-called head of the profession. You will remember that about a year ago, in a meeting of this Society, a series of papers was read, the sum and substance of which was that the great thing in a community was to have a university hospital. A visitor was present who evidently had been preaching throughout the United States that the very rich and the poor were the only people who enjoyed the benefits of a university hospital. I say to you that the reason is that the rich do not know any better, and the poor cannot help themselves. The rich love a retinue of liveried servants, and it will not be many years before the medical societies of this country will be debating with the same earnestness that the London Medical Society a year or two ago debated, the question—Has the medical man the right to enter the front door of his wealthy client,

or should he enter through the tradesmen's and servants' entrance? These so-called professors are assuming a stand at the present time that when a patient comes to them and a consultation is suggested—and this patient suggests a certain doctor who is not among the elect—he is told that "We only consult with Professor So and So, or Professor So' and So." The feeling of antipathy to this spirit is becoming widespread in this country and had its culmination in the spectacular display which occurred at Chicago not many months ago. We are informed that there are 1050 consecrated surgeons in the United States, especially ordained—so report goes—by an imported high priest from Great Britain. There are some university professors among them. Naturally, it would not do to make it too evident, but this is undoubtedly the underlying motive of this whole procedure. Furthermore, these great professors forget that the great advances in medicine for ages have been made, not by university professors, but by men who were in the active practice of their profession. A few have subsequently been made professors, but they were made professors for what they had done—they did not do much after they became professors. Furthermore, it must be recognized that a great deal of the scientific work of the country is done in hospitals that are not university hospitals, and the layman recognizes the fact more than the members of the profession realize.

There is another class in the profession, the chiefs of the medical departments of the large corporations. How are the assistants chosen? The chief looks around and picks out a young man who has a large following. He is selected as an assistant, the inference being naturally that all consultations and all operations shall be referred to the chief. The question of splitting fees in this particular series will not be touched upon.

We come now to the chiefs of the staffs of various large hospitals throughout the country. If there is one class more than the professors who have been accused of wandering about the country and offering 50% or more discount on operative cases sent to them, these are the men who are so accused. Since the American Medical Association has taken the very energetic stand that it has against fee splitting, this is no longer done. Nowadays the family practitioner collects the fee and then goes to the great surgeon and asks him if he will do the operation for one-half of what he has collected! Now then, the young man who studies medicine enters the profession with high ideals; in the course of his years of study he sees these various practices; what can be the effect? Complaint has been made that the Association of American Medical Colleges requires 72 hours of medical jurisprudence. Why not devote some of that time to the teaching of medical ethics, bearing in mind that "example is better than precept"?

We come then to the general practitioner—the man who feels that he must have a living income, and who joins a lodge and becomes the physician of this organization. He sees the rivalry going on among the big men for appointments as professors; he sees the rivalry going on among the great

men for large corporation appointments; he sees the nasty politics going on for appointments as chiefs at the various hospitals. Do you blame him if he is angry when these same great men in the profession make slurring remarks about his tactics in trying to make a competency by obtaining a position as physician of a society or lodge? The principle is the same clean through from the top to the bottom.

We must now remember that there are a great many men who have no entanglements, alliance or connections in any of these various directions, and they are the real backbone of the medical profession, just as the so-called bourgeois of France was the mainstay of that country. The trouble is that these men do not do their duty; do not join their county medical society and act as the balance of power between these various contending factions. If we can persuade these men to come in, and simply by their presence lend a dignity and tone to the meetings of the Society, it is going to help the profession a great deal. Furthermore, I believe that more frequent social functions, bringing the men together in a spirit of good fellowship will help to wipe out a great deal of the misunderstanding in the profession. If the men on top will observe the Golden Rule themselves, and not expect more of the men down below than they are doing themselves, the medical profession will evolve from that time and we can go about the world and the community at large and occupy the position which belongs to a profession which has the oldest and most honorable history in the world.

As the poet says:—

"Let us then be up and doing  
With a heart for any fate;  
Still achieving, still pursuing,  
Learn to labor and to wait."

#### REPORT OF SECRETARY.

As Secretary I beg leave to submit the following report for 1913, that is, from December 10, 1912, to December 8, 1913, inclusive.

#### MEMBERSHIP.

The total number of members for whom we have paid assessments to the State Society is 589 as compared with 556 of last year, an increase of 33 members for the year: (34 were really admitted, of whom 1 came by transfer from Los Angeles, where his assessment was paid). Of this number there are:

Paid up with us.....	558
Dropped for non-payment.....	5
Died .....	2
Transferred .....	1
Delinquent .....	23

31

589

It may be of interest as a matter of record to note the following:

In 1907 the membership was	498
1908	482
1909	482
1910	476
1911	548
1912	556
1913	589

It will thus be seen that while so-called membership campaigns have not been productive of much good in the past, a steady, persistent effort on the part of this office has led to a gradual increase in our number. There is still considerable work, however, to be done along these lines, and hoping that this may be an incentive to our members to get busy, we wish to state that the membership of the Los Angeles County Society exceeds ours by a considerable number. We should not rest until every eligible physician and surgeon within the county has joined our society. Surely a little persuasion on the part of a man's confreres should suffice to show him the benefits of membership.

#### NON-PAYMENT OF DUES.

Several persons, whose assessments to the State Society were paid, have nevertheless been dropped from our membership roll because of non-payment of dues. These names will be put in our February program, as will the names of several others who will probably be dropped about that time.

Whereas this office has been unable to collect from these gentlemen, we hope some kind friend will take up this matter with them and, if possible, succeed where we failed.

#### SCIENTIFIC MEETINGS.

Judging by the expressions of approval on the part of members who have attended meetings, we believe that the papers have been as good, if not better, this year than at any time in the past. We would like to call attention to the fact that few men comply with the rule of posting their papers in the Society 10 days preceding the meeting. Even those who prefer to talk without notes would greatly oblige physicians and encourage intelligent discussion if they would give a syllabus of their remarks—not to exceed 10 lines—which we would gladly publish in the program. The same applies to all essayists, a brief description of whose papers would likewise appear in the program. As the latter are printed by the 25th of each month, these abstracts must, of course, be furnished to the office in ample time. In future meetings, we would suggest that one medical and one surgical meeting be devoted to the reports of mistakes in diagnosis or in treatment, thus to be a contrast to the usual papers, which report either unusually clever diagnoses or remarkable results of treatment. Too often the public assumes that our judgment and skill should be perfect. If we are more honest with ourselves and the public, we will undoubtedly learn more and have fewer damage suits. We would furthermore suggest that a resolution be

introduced authorizing us to request representatives of newspapers to attend our meetings, feeling that in this way the public would be educated with far greater rapidity and success than it has been in the past when newspaper reporters have only slipped into meetings on those occasions when quasi-scientific discoveries by self-styled scientists were to be presented with great eclat. According to our present ethics and policies, the lay press is usually unable to obtain reliable information of medical doings, and in its zeal for news probably exaggerates and distorts what information it does get hold of. We feel that with proper encouragement, and with less reticence on our part, the newspapers can be trusted to properly report the transactions of our Society without giving undue notoriety to names of members, just as is done in all large medical centers abroad and is being done more commonly in the East. We would like to be able to send copies of the J. A. M. A. and the CALIFORNIA STATE JOURNAL OF MEDICINE to every important daily in this city.

#### LEGISLATION.

The Society contributed \$100 toward the work of the Public Welfare League in the latter's endeavors to get proper medical legislation carried. In addition to this, the Directors unofficially by private subscription contributed a similar amount.

The Secretary wishes to express his sorrow at the untimely death of our building scheme. Without a building of its own, such as had been planned, without the advantages which the individual members would have enjoyed in occupying such a building; without the advantages the Society itself would have obtained; without the prestige that the Society would have acquired by building such a monument as it had planned; we feel that the Society has now but little to look forward to. Its future, without a building, cannot be very much greater than its past. To quote the Secretary of the Los Angeles Society, which is engaged in erecting a building:—"Without a home we will have a loosely organized Society with transient and varying spurts of activity or inactivity, according as we elect from time to time working and non-working groups of officers."

#### ENTERTAINMENT.

The Secretary feels that the Society does not show sufficient courtesy to physicians or laymen who come as guests of the Society to address its members. At the last minute they are frequently shunted to the end of the program so that because of the lateness of the hour not sufficient consideration can be given to their remarks. We know it to be the custom of some of the county societies in the interior to pay the traveling expenses of men who come from San Francisco to address their meetings, and those of our members who have gone to Los Angeles for similar purposes tell us that several homes or clubs are offered them, either the host or the Society bearing the expense. We see absolutely no reason why a society like ours



cannot make an arrangement with some one or two clubs here to do the same for our guests.

Balance on hand Dec. 10, 1912.....	\$1485.88
Collected from members.....	7134.25
Subrental of Library.....	150.00
Sale of duplicates.....	16.00
Interest on Relief Fund.....	450.00
Advance repaid by Relief Fund.....	5.00
Gift from Dr. Wortmann.....	5.00
Milk Commission (telephones & telegrams)	7.09
Banquet, 1912.....	177.75
Repaid for binding.....	6.85

Plus Pac. Tel. & Tel. check sent Sept. 15, lost in transit.....	\$9427.82 9.05
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Making a total of.....\$9436.87

We disbursed by check—

Telephone .....	\$ 152.70
Entertainment Committee (Banquet, 1912)	172.90
Secretary's salary ('12) and Bond ('13)...	205.00
Committee on Necrology (1912).....	5.40
Rent of Library.....	1200.00
Salary office assistant.....	900.00
Laundry .....	18.00
Relief Fund (150 repaid general fund, see Jan. Voucher 491).....	305.00
Incidentals, including water, insurance, lamps, safe dep. box, repairs to type writer, membership Chamber Com., operation stereopticon, etc.....	351.62
Printing and Stationery.....	508.30
Assessment to State Society on 589 members .....	2356.00
Loan State Society (90 days—due Jan. 15, 1914).....	1000.00
Library: Foreign jnls. for '12.....	\$ 618.53
Domestic jnls., 1912.....	13.00
Domestic jnls., 1913.....	63.00
Domestic jnls., 1914.....	6.00
State Soc. lieu exchanges.....	180.00
Filing files.....	84.40
Book rests.....	10.00
Med. Lib. Assn.....	10.00
Binding .....	347.05

\$1331.98 \$1331.98

\$8761.36 \$8761.36

Leaving a balance 'of.....\$ 675.51

The following approximate amounts, bills for which are not yet received, will, of course, have to be paid by December 31st:

New book stack for Library.....	\$ 70.00
Century Dictionary.....	76.95
Foreign jnls., 1913 (about).....	618.00
December printing (ballots, return envelopes, postals & p'rms—about)	45.00
Water for Nov. and Dec.....	4.00
Filing foreign files (about).....	100.00
Secretary's salary, 1913.....	200.00
Xmas present Butler Bldg. employees	10.00

\$1123.95

Bal. in bank.....	\$ 675.51
Due from St. Soc. Incl. int. on loan.....	1015.00

	\$1690.51
Bills due approximately.....	1123.95

Surplus of approx.....\$ 566.56

(This is the first time that the Society's books have been so kept as to show the actual financial status were the Society to go out of business December 31. The showing, when one considers the large sums expended for library and the sums expended by the Building Committee and the Committee on Legislation, is a most creditable one and cannot be compared with that of last year when no account was taken of outstanding bills, especially those of the library.)

As the detailed report of the Librarian will show, he has authority granted him by the Board of Directors to draw \$139.43 in addition to the sum required for outstanding bills.

Respectfully submitted,

(Signed) RENÉ BINE.

## REPORT OF THE LIBRARIAN.

To the President and Members, S. F. Co. Medical Society.

Gentlemen:—The progress of our library for the past year may, I think, be considered as satisfactory.

Restricted by our limited income, we have had to confine our efforts as heretofore, to the acquisition of the more important clinical journals and to the completion of their files. We have not subscribed to purely scientific journals, considering that these, of more academic interest, should be kept by the two university libraries, particularly the Lane Library, which is open to the medical public, and whose files we have, in a measure endeavored to supplement rather than duplicate.

The increased interest and increased frequency with which the library is consulted show, I think, that there is room for two medical libraries in San Francisco, one a large academic one, the other centrally located and easily accessible, a working library for the general practitioner. It is with this end in view that we have tried to develop our collection of books and journals.

The purchase of more expensive text-books, systems, and hand-books, those which not every man is able to afford to buy for himself, would be very desirable should our means permit, but we have heretofore had money for the purchase of journals only and not for books. What books we have, have been received for the most part from the CALIFORNIA STATE JOURNAL in exchange for reviews, and as gifts. We should like to thank the reviewers for their aid, and to further urge promptness and willingness to help us with these services. We are very grateful to those members who have presented us with books; and would urge members, if they have newer text-books that they can spare to give them to the library. All such donations are acknowledged in the monthly programmes.

We greatly need more room, and now that the scheme for a building of our own has seemed impossible, must see what other remedy is available; we have made arrangements to have a shelf built out from between the two last windows of the meeting room, as a temporary expedient.

We have during the past year sent circular letters to the largest foreign publishers requesting exchange of journals with the CALIFORNIA STATE JOURNAL and the sending of books for review. Some of them have complied, and we now receive some journals free, through the STATE JOURNAL, for whose subscriptions we formerly had to pay. We have also received a number of foreign books for review.

We have sold some duplicates—not as many as last year, having less on hand.

We have recently bought a Century Dictionary, in compliance with numerous requests from members.

We have ordered journals to complete the last 20 years' files of the more important foreign medical weeklies, these have been ordered abroad,

and should arrive in a month or two. We have purchased in the last year..... 17 volumes  
Received from the CALIFORNIA STATE

JOURNAL .....123 volumes  
By gift..... 53 volumes

Total .....183 volumes

We have 384 volumes bound.

We subscribe to, or receive from the STATE JOURNAL 178 journals. In presenting the financial statement included in the Secretary's report we may explain that before this year all foreign subscriptions were paid for at the end of the year when the journals were received, thus leaving the library with a considerable debt on the 1st of each January; we changed this in the beginning of 1913, so that the library has now paid up, or has the money to pay up all subscriptions in advance.

Respectfully submitted,

(Signed) LEO ELOESSER,  
Librarian.

#### REPORT OF THE MILK COMMISSION

Mr. President and Members of the Society:

The Milk Commission of the San Francisco County Medical Society has held 14 meetings this year.

Two new dairies have been certified.

The American Dairy at Oakdale, California, was certified in October 1912. After several months its counts increased to be steadily about our limit, i. e., 10,000 per c.c. The dairy changed management, and was found in unsatisfactory condition on individual visits by three of the Commission. An effort was made to have conditions improved under a resident inspector from the University of California, but after a ten days' drill on technic no permanent improvement was found, and your Commission removed its certification in August 1913. This experience makes us realize that the certified dairy must not only be built to satisfy our requirements, as this dairy did in the fullest degree, but it must be managed by an intelligent trained dairyman, such as the University and the State Farm at Davis are able to supply. An inexperienced man is as much out of place in a certified dairy as an inexperienced nurse would be in a modern operating room. Tiled floors and enameled furnishings mean little unless each step of technic is understood and executed.

In December 1912 the Peacock Dairy at Bixler was certified. This dairy had built its barn without consulting our experts, and had imported a tuberculin tested herd of Holstein cattle from Wisconsin. The herd was remarkably free from tuberculosis at our first test, and with certain modifications we accepted the plant and certified the dairy. The milking machine was in use. Theoretically, this should obviate bacterial invasion of milk. Practically, we were convinced that it did not, as at no time did this milk run as low as the other certified dairies. The fat content of the milk—due to the Holstein herd—was seldom 3.5 and ranged most of the time below 3.3, which is

the requirement for city milk. As our suggestion to add some Jerseys to the herd—and thus increase the fat content—was not taken, it became the duty of the Commission to withdraw this certification on July 20, 1913.

The San Ramon Dairy at Walnut Creek has been sending certified milk to Oakland for some months, and was certified by your Commission August 28, 1913. This dairy is managed by the owner.

Certified milk from our dairies now reaches Sacramento, Suisun, Vallejo, San Jose, San Mateo, the whole of Marin County, and is carried on the Southern Pacific System and Ferry boats—250 quarts a day.

Our producers are the Sleepy Hollow Ranch at San Anselmo, the Timm and Hutton dairies at Dixon, and the San Ramon Dairy at Walnut Creek. In January 1913 3170 quarts of certified milk were sold daily in San Francisco County; they are now selling 3659 quarts a day, a gain of 489 quarts for the year.

It seems to the Commission that this is not the type of growth a product certified by a society the size of ours should have. We expect to send you more data about the milk monthly during this next year, and wish to secure your support for a product whose standard is kept up by the steady interest of your Commission. Under the growing prevalence of Pasteurization of the city's supply of commercial milk, we are rapidly reaching the condition of New York, where the only unpasteurized milk is certified milk.

During the year we have kept an inspector in the local field who visits all distributing stations and examines milk on wagons, and watches the handling of certified milk in the city. Acting on her reports of repeated abuses, we have refused to allow the Crystal Creamery to handle certified milk at all, and have notified our producers to that effect.

Our relation to the University of California has changed during the year. On the rearranging of the Department of Agriculture under Dean Hunt, a ruling preventing appointees of that department from earning money on the outside was made. The University has taken over the work of experting the milk, furnishing the veterinary examination as well as the chemical and bacteriological monthly examinations. The Recorder's Office collects the bills for this work and renders us a quarterly financial report on the same. The arrangement is in effect for a year from July 1, 1913.

The President of the Commission attended the annual meeting of the Medical Milk Commissions of the United States in Minneapolis, as a delegate from the Alameda and San Francisco County Medical Milk Commissions. Emphasis on the care of milk in the home was made by the Rochester, N. Y., Commission, who had found over 50% of refrigerators inadequate in holding milk below 50°, and many of them far from sanitary.

The value of certified milk in infant feeding has again this year been proven on the foundling babies of the city. A death rate of 3.2% is theirs against 9.+ for the city. These babies are uniformly fed

on modified certified milk, and are all under 2 years of age. Two hundred and forty were cared for this past year. The Commission regards itself as peculiarly fortunate in having this practical demonstration of the advantage of clean milk as a basis for infant feeding, for the vital statistics of so large a group cannot be refuted.

In closing, your Commission wishes to urge your co-operation in its efforts to promote the understanding and appreciation of its work for public health in securing and upholding certified milk for our San Francisco market.

Respectfully submitted,

ADELAIDE BROWN,  
President.

## SOCIETY REPORT

### ALAMEDA COUNTY.

The annual meeting of the Alameda County Medical Association was held at the Hotel Oakland on Tuesday evening, December 16, 1913. The meeting was called to order by the President, Dr. M. L. Emerson, at 8:30.

The minutes of the previous meeting were read and approved.

The members then listened to a very interesting address by Mr. A. J. Pillsbury, of the California State Industrial Accident Board on the subject of the "Employees' Compensation, Insurance and Safety Act." Dr. Philip Mills Jones, Secretary of the State Medical Society, was present and also made a few remarks on the subject, calling particular attention to the efforts of insurance companies to make a schedule of fees for physicians called to attend cases under this act which will be altogether too low.

Dr. Dudley Smith made a motion, seconded by Dr. Reinle, that the President appoint a committee of three to confer with the State Industrial Accident Board in regard to the schedule of fees to be paid physicians attending cases under this act and to report to this Association before any definite action is taken in the matter. Carried. The President stated that he would leave the appointment of this committee to the new President. The new President, Dr. Dudley Smith, later made the following appointments on this committee: Dr. G. G. Reinle, Chairman; Dr. L. P. Adams and Dr. Alvin Powell.

The reports of the Chairman of the Medico-Legal Committee, Secretary of the Council and of the Association and the Treasurer were received. The Treasurer's report showed a balance of \$1412.74 with one bill of \$10.00 still to be paid. Dr. Dukes moved that the reports be accepted. Seconded and carried.

Dr. Pauline Nusbaumer, Chairman of the Board of Tellers, submitted the following report: President, Dr. Dudley Smith; Vice-President, Dr. G. G. Reinle; Secretary-Treasurer, Dr. Elmer E. Brinckerhoff; Councillors, Dr. J. A. Ellis, Dr. W. H. Irwin, Dr. Alvin Powell, Dr. G. P. Reynolds, Dr. H. N. Rowell, and Dr. W. H. Strietmann; Delegates, Dr. S. H. Buteau, Dr. M. L. Emerson, Dr. O. D. Hamlin, Dr. C. W. Page and Dr. G. G. Reinle; Alternates, Dr. L. P. Adams, Dr. A. A. Alexander, Dr. D. Crosby, Dr. C. A. Dukes, Dr. A. F. Gillihan, Dr. A. S. Kelly, Dr. C. P. Pond, Dr. A. M. Smith and Dr. R. T. Sutherland.

Short speeches were made by the retiring and incoming Presidents and the Vice-President. The new President stated it as his desire to make the meetings of the coming year clinical ones as far as possible, believing that in this way they can

be made much more interesting, with a consequent increase in the attendance.

There being no further business, the meeting adjourned.

ELMER E. BRINCKERHOFF, Secretary.

### CALIFORNIA ACADEMY OF MEDICINE.

The California Academy of Medicine held its regular meeting on December 22, at the rooms of the County Society.

#### Scientific Program.

Asymmetrically Lower Blood Pressure in an Instance of Asymmetrical Raynaud's Disease. Drs. Montgomery and Culver. Discussed by Drs. Rixford, Kilgore and Alverarez.

The following officers were duly elected: President, Dr. T. C. McCleave; Secretary, Dr. Saxton Pope; Treasurer, Dr. H. M. Sherman; Vice-President, Dr. Orn Fitch Cheney.

### MERCED COUNTY.

The Merced County Medical Society held a well-attended and highly interesting meeting December 4th at the office of the Secretary in the Shaffer Building. A number of doctors from out of town were present, among whom were Drs. Julien and Reardon of Turlock and Dameron of Stockton. An interesting paper was read by Dr. Dameron entitled, "Closure of Abdomen in the Face of Sepsis." The doctor was backing up some new ideas in surgery with a recital of a large number of successful cases and the instructive discourse drew forth a lengthy discussion which was highly enjoyed by all present.

The annual election of officers resulted as follows: President, Dr. E. A. Julien, Turlock; Vice-President, Dr. Brett Davis, Merced; Secretary, Dr. H. Kylberg, Merced; Treasurer, Dr. W. E. Lilley, Merced; Board of Censors, Dr. D. Zirker, for three years; Dr. B. Davis, for two years; Dr. E. S. O'Brien, for one year. Delegates to the State Medical Society for two years, delegate, Dr. F. B. Reardon of Turlock; alternate, Dr. P. N. Jacobson of Turlock.

The Merced County Medical Society has enjoyed a prosperous and harmonious year, and has had the pleasure of entertaining some distinguished visitors during the course of the year. Visitors at last night's meeting, not physicians, but taking an active part in the banquet prepared at Hotel El Capitan, were the complete dental faculty of Merced, Drs. Smith, Heitman and Peck, also the Hon. F. Bondshu, assessor of Mariposa county, who entertained at the table with well chosen and witty remarks.

The meeting, as usual, closed in peace and harmony at 1 g. m.

H. KYLBERG, Secretary.

### MONTEREY COUNTY.

The Monterey County Medical Society at a meeting held at the Hotel Abbott, Salinas, January 9, 1914, elected the following officers for the year: President, Dr. Garth Parker; Vice-President, Dr. L. B. Graham; Secretary, H. T. Crabtree; Treasurer, Dr. Jno. Parker; Censor, term to expire in 1915, Dr. J. A. Beck; Censor, term to expire in 1916, Dr. Garth Parker; Delegates to State Society, Drs. H. T. Crabtree and L. B. Graham; Alternates to State Society, Drs. Garth Parker and John Beck.

H. T. CRABTREE, Secretary.

### RIVERSIDE COUNTY.

The last meeting of our County Medical Society for 1913 was held at the Mission Inn, December 8th.

Inasmuch as this was the last meeting of the year the regular annual election of officers was



held. Dr. J. H. Holland of Riverside was elected President; Dr. E. H. Wood of Arlington was elected Vice-President, and Dr. George E. Tucker was elected Secretary and Treasurer. Dr. H. R. Martin was elected Delegate for 1914-1915, and Dr. John C. King of Banning was elected Alternate.

As is our regular custom for the December meeting, each member of the Society present was called upon to present a case report. A series of unusual cases of throat infection were reported by several members of the Society and Dr. Stanley Black of Pasadena, who was one of the guests for the evening, discussed these cases from a bacteriological and laboratory standpoint.

During the year 1913 nine regular meetings were held, with a general average attendance of twenty-one doctors, and an average of eighteen members per meeting. Six new members were added to the society during the year.

There has been an average attendance of three guests at each meeting, including Dr. J. B. Murphy of Chicago, Dr. Max Rosendorff of Portland, Oregon, Dr. J. H. Webster of Chicago, Dr. R. Smedley of Salt Lake City, Dr. Olga M. McNeil of Los Angeles, Dr. Stanley Black of Pasadena, and nearly every member of the San Bernardino County Medical Society has attended one or more meetings.

GEORGE E. TUCKER, Secretary.

#### SAN JOAQUIN COUNTY.

The regular monthly meeting of the San Joaquin County Medical Society was held at the offices of Drs. B. J. and D. R. Powell, Friday evening, November 28, with Dr. H. E. Sanderson in the chair. The following members were present: Drs. H. E. Sanderson, Linwood Dozier, J. T. Davison, Mary Taylor, Barton J. Powell, J. A. Young of Oakdale, D. R. Powell and R. T. McGurk.

After the reading of the minutes the following business was transacted: Drs. S. P. Tuggle, J. T. Davison and W. F. Priestly were elected to membership, and the names of seventeen members were placed in nomination as candidates for the Board of Directors for the coming year.

The business of the meeting completed, Dr. Sanderson called upon Dr. Dewey R. Powell to read his paper, "The Submucous Resection of the Nasal Septum." The subject was well presented and made especially instructive with the aid of drawings and plates projected on a screen by Dr. Dozier. Further points were brought out in the discussion amongst the general practitioners present.

R. T. MCGURK, Secretary.

#### SANTA CRUZ COUNTY.

Santa Cruz County Medical Society met December 12th in Santa Cruz. The following officers were elected:

Dr. F. H. Koepke, Watsonville, President; Dr. W. H. Keck, Santa Cruz, First Vice-President; Dr. A. N. Nittler, Davenport, Second Vice-President; Dr. G. P. Tolman, Watsonville, Secretary-Treasurer; Dr. H. G. Watters, Watsonville, Censor three years; Dr. P. T. Phillips, Santa Cruz, Delegate to State Meeting; Dr. E. E. Porter, Watsonville, Alternate.

It was decided to have two papers or clinics at each meeting. At the next meeting Dr. Koepke will read a paper, discussion to be opened by Dr. Keck. Dr. Nittler will also have a paper, to be discussed by Dr. H. G. Watters. Twenty-five dollars was donated to Dr. Geo. H. Tucker, to help defray expenses incurred at the last legislature.

GEORGE P. TOLMAN, Secretary.

#### SONOMA COUNTY.

At the January meeting of the Sonoma County Medical Society, the following resolution was made to send to the Medical Society of the State of California:

"Whereas, The fees offered by the Casualty

Companies doing business under the recently enacted 'Workmen's Compensation Act,' are inadequate for the services required; therefore, be it

"Resolved, That we, the members of the Sonoma County Medical Society, request that the proper officials of the Medical Society of the State of California take up the matter with the Casualty Companies and State Officials concerned for proper adjustment."

The following officers were elected in December: President, Dr. J. W. Scamell of Santa Rosa; Vice-President; Dr. F. E. Sohler of Geyserville; Secretary, Dr. A. R. Howard of Santa Rosa; Treasurer, Dr. F. O. Pryor of Santa Rosa; Censor, Dr. S. S. Bogle of Santa Rosa; Delegate, 1915-1916, Dr. Jackson Temple of Santa Rosa; Alternate, Dr. J. W. Cline of Santa Rosa.

ALLEN R. HOWARD, Secretary.

#### VENTURA COUNTY.

The Ventura County Medical Society held a pleasant reunion at Pierpont Inn, December 10th, when the members were guests of Dr. Ralph W. Avery, of Oxnard, who retires from the presidency of the organization. All sections of the county were represented. A full-course dinner was enjoyed, followed by a discussion on topics of interest to the profession; Dr. Teubner reading a timely paper.

The following officers were elected for the coming year: Dr. Benj. E. Merrill, Santa Paula, President; Dr. Allen Peek, Oxnard, Vice-President; Dr. H. B. Osborn, Fillmore, Secretary.

#### BOOK REVIEWS

##### "Praktische Winke für die chlorarme Ernährung."

By Prof. Dr. H. Strauss. Published by Karger, Berlin, 1914.

This is a second edition of Strauss' well-known teachings on the question of salt-free diet, a good portion of which is incorporated in his larger work on the dietetic treatment of internal diseases. A number of tables of value to the student of dietetics are here included; likewise recipes for many dishes made palatable in spite of the absence of sodium chloride in the cooking. To those familiar with the indications for a salt-free dietary, the value of such a little work is obvious.

R. B.

##### Dorland's American Illustrated Medical Dictionary.

New (7th) Edition Revised and Enlarged. Dorland's American Illustrated Medical Dictionary. A new and complete dictionary of terms used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry, Veterinary Science, Nursing, Biology and kindred branches; with new and elaborate tables. Seventh Revised Edition. Edited by W. A. Newman Dorland, M. D. Large octavo of 1107 pages, with 331 illustrations, 119 in colors. Containing over 5,000 more terms than the previous edition. Philadelphia and London: W. B. Saunders Company, 1913. Flexible leather, \$4.50 net; thumb indexed, \$5.00 net.

This new edition of the dictionary is even more valuable than any previous edition and is in constant use on the editorial desk. From the frequency with which it is used to determine and correct the errors of some contributors, it would appear to be well worth while for almost anyone contemplating the perpetration of a medical article to purchase a copy.

##### A Reference Hand-Book of Gynecology for Nurses.

By Catharine Macfarlane, M. D. Gynecologist to The Woman's Hospital, of Philadelphia. Second Edition, thoroughly revised. 32 mo. of 156 pages, with original line-drawings. Phila-

delphia and London: W. B. Saunders Company, 1913. Flexible leather, \$1.25 net.

This little book of 150 pages covers very fully, yet most concisely, the subject of gynecology as taught to nurses. In my opinion, the book could well be used as a text-book in connection with lectures, and as a reference handbook for nurses it is certainly very valuable. A. E. R.

**A Text Book of Biology.** For Students in Medical, Technical and General Courses. By William Martin Smallwood, Ph. D. (Harvard), Professor of Comparative Anatomy in the Liberal Arts College of Syracuse University, and in charge of Forest Zoology in the New York State College of Forestry at Syracuse. Octavo, 285 pages; illustrated with 243 engravings and 13 plates, in colors and monochrome. Cloth, \$2.75, net. Lea & Febiger, publishers, Philadelphia and New York, 1913.

In this small volume of two hundred and eighty pages the author has attempted to cover the wide field of general biology in such a way as to deal specifically with the more important subdivisions of botany zoology, embryology, bacteriology, immunity, heredity, etc. The text is well written and attractively illustrated, but the scope of the volume is much too wide. The whole is of the most elementary character, probably well adapted for students in high or preparatory schools or for the general reader, but as a text-book for medical students or as a volume of reference for the medical practitioner it cannot be recommended. E. C. D.

**The Surgical Clinics of John B. Murphy, M. D.,** at Mercy Hospital, Chicago. Volume II, Number VI (December). Octavo of 186 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1913. Published Bi-Monthly. Price per year: Paper, \$8.00; cloth, \$12.00.

Contents: Tuberculosis of the Lung; Production of Artificial Pneumothorax by Injection of Nitrogen according to Dr. Murphy's Method. Bone Cyst of the Radius. Pyonephrosis: Drainage. Exostosis of Radius and Ulna. Ununited Fracture of Radius, Previously Plated; Transplantation of Bone. Ankylosis of Elbow. Laminectomy for Tuberculum of Spinal Column, with Compression of Spinal Cord; Kyphosis and Lateral Curvature; Motor Paralysis. Subcutaneous Abscess Following Tuberculosis of the Spine; Aspiration and Injection of Formalin and Glycerin Solution. Undescended Testicle in Inguinal Canal. Cholelithiasis; Stones in Common Duct, with Intense Jaundice. Students' Clinic at Opening of Session this Year. Metastatic Carcinoma of Femur. Traumatic Sarcoma of Femur. List of Cases Operated on and Demonstrated by Dr. John B. Murphy at Mercy Hospital During the Week of the Clinical Congress of Surgeons of North America, Nov. 10-15, 1913. Index to Volume II.

**Theorie und Praxis der Inneren Medizin.** Dr. Erich Kindborg. Vol. III. Published by S. Karger, Berlin. 1914.

This volume completes one of the most valuable systems of medicine that has appeared in many years. The enthusiastic appreciation evoked by the first two volumes can be equally bestowed on this concluding volume. The admirable plan of presentation, the painstaking thoroughness and the unusual excellence of the sections on treatment that marked the initial volumes are sustained throughout.

The contents comprise: Diseases of the Kidneys and Urinary Apparatus; Diseases of the Blood; Diseases of the Nervous System; the Infectious Diseases, and the more important Poisons. Of especial note are the clear exposition on anatomical basis of the diseases of the spinal cord; the practical arrangement of the various poisonings accord-

ing to environment, occupation and habits; the excellent presentation of the subject of nephritis.

To the above may be added the statements that appeared in the review of the first two volumes, that the language used is simple, clear and concise; each chapter includes the anatomy, physiology, physics, chemistry and pharmacology requisite for a complete and clear understanding of the subject under discussion; the literature of the medical world is gathered and digested to be presented in the light of the writer's experience and judgment; methods of clinical examination are fully presented; each subject is placed in coordination with the sister sciences and in its proper relation to the scheme of medical science.

It is a book fit to occupy the highest place among text and reference works. G. H. T.

**A Practical Treatise on Medical Diagnosis.** For Students and Physicians. By John H. Musser, M. D., LL. D., late Professor of Clinical Medicine in the University of Pennsylvania; formerly President of the American Medical Association, etc. New (Sixth) edition, revised by J. H. Musser, Jr., B. S., M. D., Instructor in Medicine in the University of Pennsylvania; Assistant Physician to the Philadelphia Hospital; Physician to the Medical Dispensary of the Presbyterian Hospital; Physician to the Medical Dispensary of the Hospital of the University of Pennsylvania. Octavo, 793 pages, with 196 engravings and 27 colored plates. Cloth, \$5.00 net. Lea & Febiger, publishers, Philadelphia and New York, 1913.

This valuable standard work has undergone a very thorough and complete revision which has brought it up to date in every particular and in addition has conferred the benefit of a judicious condensation of the more voluminous portions, thus rendering the book much more wieldy and practical. The section on Objective Diagnosis is especially to be commended, presenting, as it does, those valuable and so frequently neglected pieces of evidence that the physician should take into account when he is making an initial examination of a patient. There is a world of experience and wisdom in this chapter which each medical man should acquire and use constantly. The hundred-page section devoted to Laboratory Diagnosis is likewise valuable. It is condensed to the absolute essentials and contains only such technic as can be exercised in any physician's laboratory. The second part of the volume is devoted to Special Diagnosis and differs in no way from the other recognized books on this subject. Regarded as a whole, the work is the equal of any of the standard books in its field but presents no special characteristics that could be regarded as novel or original; it is a stereotyped example of students' textbook and practitioners' reference work stamped by conservatism and tradition. G. H. T.

**Diseases of Women.** By Chas. A. L. Reed. Published by D. Appleton & Co., N. Y., 1913.

The arrangement of the various subjects is a decided departure from that of the usual text book devoted to diseases peculiar to women. For instance, the very excellent article under the general head of "Menstruation and Its Disorders," by Dr. Dan Milliken, of Hamilton, Ohio, begins near the end of the book—page 756. On the other hand, subjects of much less practical every-day importance are given preference in the arrangement, to wit "Malformations," a subject which the author has dealt with in considerable detail, is the first subject considered. Again in addition to the topics usually considered under the head of gynecology, the following have been treated in detail, viz.: surgery of the rectum, certain obstetric operations and surgical conditions of the kidneys, ureters, and of the breast.

The diagnosis of rape is as good as any abstract that the reviewer is familiar with on the subject

and the points brought out under this heading should be familiar to any physician who assumes to pass judgment upon a subject so important that its decision is vital to the future welfare of any human being.

What the author has written on lacerations of the perineum would be dealt with in detail if space permitted, but the reviewer must take exception to the advice that the urine should be drawn exclusively by catheterization for at least the first week, for we know that infections can be more easily prevented by pitcher douches following urinating than by the many disadvantages of so promiscuous catheterization.

The reviewer was further disappointed by the omission of the continuous silkworm-gut suture as evolved by Dr. Geo. B. Somers of this city, than which there is no better universal operation for the repair of a lacerated perineum. If some high-sounding name from an European center could have devised so simple and practical an operation it would be world-famous.

Likewise, the subject of cystocele is not brought up to date, as the most satisfactory operations for its correction are entirely omitted.

The infections of the genito-urinary tract in women have been entered into with considerable detail and are excellent.

The articles on ovarian embryomata (dermoid cysts and teratoma) are especially to be commended.

But on the whole, the book is a most valuable asset to any medical library—especially to the physician who by force of circumstances is compelled to handle this class of work without the opportunity of giving it special attention. C. J. T.

**Treatment of Internal Diseases.** For Physicians and Students by Prof. Norbert Ortner of the University of Vienna—Edited with Additions by Nathaniel Bowditch Potter, M. D., Assistant Professor of Clinical Medicine at Columbia University (College of Physicians and Surgeons), New York. Translated by Frederic H. Bartlett, M. D. Second Edition in English revised and reset from the Fifth German edition. J. B. Lippincott Company, Philadelphia and London. Price \$5.00.

This book covers in a detailed and exhaustive manner the modernized treatment of internal diseases. To the internist, and general practitioner as well, it must appeal at once as a reference work of inestimable value, due to the clear and systematic manner in which the text is written. Throughout this work great stress is placed on the pathological physiology of the diseases in question so that a clear conception of the therapeutic measures advised by the author are at once grasped by the reader's mind. Unlike most American books on therapeutics, it does not only mention the names of famous cures but describes and discusses their relative values and the results he had obtained with them personally. The elaborate manner in which drugless methods of treatment are described must be very gratifying to the reader who appreciates the importance of dietetic, therapeutic, mechanical and climatic effects on diseases. When the author recommends a particular climate or altitude he does not merely say a warm or a cold climate, a high or a low altitude, but mentions the ideal places which are to be found both in Europe and America, giving the reader a wide choice of health resorts to choose from.

When drugs are recommended their physiological action is discussed in detail and their toxic qualities carefully considered. Examples of prescriptions showing the best drug combinations are plentiful throughout the text. Many of the new drugs approved by the Council on Pharmacy and Chemistry are personally recommended by the au-

thor. The treatment of tuberculosis with tuberculin is ably described.

The only regrets the reviewer experiences are that there is no chapter in the book giving the modern treatment of Syphilis and that Radium Therapy was not taken up in the text, as the opinion of such a great clinician as Ortner on these modern methods of treatment would be of the greatest value to the readers of this work.

M. A.

**Oral Surgery.** A Text-Book on General Surgery and Medicine as Applied to Dentistry. By Stewart Leroy McCurdy, M. D., Professor of Anatomy and Oral Surgery, School of Dentistry, University of Pittsburgh, Pa. Dr. Appleton & Co., New York and London, 1912. \$3.00.

The author in his preface raises the question as to "whether oral surgery belongs to general surgery or to dentistry." Surgery of the mouth, jaws and contiguous parts has come to be known as oral surgery, and forms an important specialty of dentistry. This specialty has really been developed and raised to its present importance by men who were practical dentists, but who had passed through the training of the medical and surgical curriculum.

There can be no question as to whether it belongs to general surgery or dental surgery for it has been developed from dental surgery and occupies an important position in the curriculum of all of our dental colleges; while it is not given place, with but very few exceptions, in the medical curriculum.

The educated dentist is fully qualified to deal with all surgical diseases and injuries of the mouth and jaws, and to much better advantage from every standpoint than is the general surgeon by reason of his more intimate knowledge of the parts involved; the diseases and injuries to which they are subject, and by his higher degree of skill in oral manipulations.

The book in a certain way is a disappointment from the fact that one is led from the title—a pretentious one—to look for a more or less exhaustive treatise upon the subject of which it treats. The work is divided into two parts, General Surgery and Oral Surgery, followed by an Appendix composed of quiz questions upon the text.

Part 1. General Surgery, contains 97 pages, which is altogether too limited a space to give to so great and important a subject as the Principles of Surgery. We would suggest that in a second edition this subject be considerably elaborated for the benefit of dental students if the book is to be adopted by our dental colleges.

Part 2. Oral Surgery, is much more elaborately worked out (335 pages) but could with advantage be considerably elaborated. Brevity is sometimes the soul of wit, but this in other respects much to be desired feature can be carried too far in preparing a text-book. We believe the book would be greatly improved if the above suggestions could be carried out.

The Appendix (24 pages) is devoted to a series of quiz questions, the value of which is doubtful.

The author has written from the standpoint of the general surgeon and not from the vantage ground of the dentist, consequently he occasionally falls into error. Not many dentists will for instance agree with the following: "During extraction of teeth many accidents occur requiring the services of a surgeon. Fractures of the mandible or a considerable portion of the maxilla may occur requiring replacement or wiring. Slipping forceps or excavators may perforate important structures and injure an artery or nerve, resulting in dangerous complications," etc. The extraction of teeth by the average dentist is very rarely, practically never, attended by such accidents, and if such should occur the services of a surgeon would not be required by any dentist worthy of the name. It is only in the hands of quacks and incompetents



that such accidents can be at all common in these operations.

On the whole the book is well written and will prove a valuable help to the dental student who is preparing for examinations and to the busy practitioner who has not time to read a more elaborate text-book upon the subject.

J. S. M.

**Pyorrhea Alveolaris.** By Fredrich Hecker, B. Sc., D. D. S., A. M., M. D. A monograph of 157 pages and 32 illustrations. Published by C. V. Mosby Company. St. Louis, Mo., 1913. Price \$2.00.

Pyorrhea Alveolaris is a subject which is attracting more and more attention not only by the dental specialist but by the general practitioner of medicine as well, by reason of the grave dangers which are present in the disease from local and general sepsis.

We are in full accord with the author in the statement in his preface "that the disease is the result of constitutional and exciting causes which lower the vital resistance of the alveolar process, gum and peridental membrane." Also that this affection is responsible for many diseases in remote organs such as the eye, the ear, the tonsils, the throat, the heart, etc., due to septic infection through the lymph channels and the general circulation.

We stand aghast, however, when in Chapter 1 he enumerates eleven varieties of the disease. There is confusion enough already in the literature upon the etiology and diagnosis of this disease, but this array of special varieties of pyorrhea alveolaris increases the confusion and renders "confusion worse confounded."

The author would have us believe, seemingly, that nearly all inflammatory diseases of the oral cavity which result in the formation of pus are forms of pyorrhea alveolaris, and does not seem to be able to distinguish between this disease and the common varieties of gingivitis and stomatitis, the results of systemic and local conditions.

Pyorrhea alveolaris, so-called, is a disease which attacks the alveolar process, the peridental membrane and the gum, and is a progressive affection due to a lowered vital resistance of these tissues, brought about by constitutional conditions, among the most frequent of which may be named faulty metabolism and faulty elimination.

In the treatment of these many, so-called, varieties of the disease as classified by the author, the prominent and central thought is the employment of autogenous vaccines, which he recommends in all cases in conjunction with constitutional treatment, regulated diet, and the ordinary local treatment of cleansing the mouth, scaling the concretions when present, and antiseptic or astringent mouth washes or both.

Several of the varieties enumerated as pyorrhea alveolaris are simple cases of gingivitis and stomatitis, due to passing constitutional disturbances or local irritants of various kinds, and which are readily amenable to simple treatment, such as clearing the bowels and the removal of local irritants, the cleansing of the mouth and teeth and the application of a 25% solution of iodine in glycerole to the inflamed tissues.

The tendency of so many pyorrhea specialists to magnify every little inflammatory affection of the oral cavity accompanied by pus into a form of pyorrhea alveolaris is a great mistake. True pyorrhea alveolaris is by no means as common a disease as some believe, and the sooner this is realized and corrected the better it will be for the honor and good name of the dental specialist.

The making and employment of autogenous vaccines should not be undertaken by anyone who has not received special and careful training in bacteriology and serum therapy. If vaccines are used they should be employed under the direction and supervision of a specialist in serum therapy. The opsonic index should be taken in every case

to be so treated, and this examination repeated after each dose of the vaccine, as this is the only safe and reliable method of ascertaining the effect of the previous dose and whether the dose needs to be increased or diminished to establish the positive phase in the opsonic index. Clinical symptoms are often misleading and positive harm may be done by relying alone upon these symptoms.

The photomicrographs in the Chapter on Pathology are so poorly executed as to render them practically valueless.

J. S. M.

**Anatomy Descriptive and Applied.** By Henry Gray, F. R. S., Fellow of the Royal College of Surgeons; lecturer on Anatomy at St. George's Hospital Medical School, London. New (English) edition, thoroughly revised and re-edited, with the Basle Anatomical Nomenclature in English, by Robert Howden, M. A., M. B., C. M. Imperial octavo, 1407 pages, with 1126 large and elaborate engravings. Cloth, \$6.00 net; leather, \$7.00, net. Lea & Febiger, publishers, Philadelphia and New York, 1913.

The appearance of two new editions of Gray's Anatomy—one American and the other English, gives the student an excellent opportunity to make comparisons. In the new English edition the Basle Anatomical Nomenclature is given first place. It is given in English, and is a welcome advance over the terminology ordinarily accepted, as is still adhered to in the new American Edition, where the Basle Nomenclature is given second place in parentheses.

Prof. Howden has in this new English edition very consistently added at the end of the work a glossary of the Basle Anatomical Nomenclature. The equivalents of the three systems—the BNA in English, in Latin and, the ordinary terminology—are arranged in parallel columns, so that all can be commanded at a glance. This combination makes it very convenient for those who desire to perfect themselves in this subject.

In a recent review of the American Edition (Calif. State Jour. Med., vol. XI, p. 472) the writer made certain criticisms and laudatory comments, on the paucity and character of the illustrations, and general character of the work. The criticisms are equally applicable with slight modification, to the English Edition.

The latter begins with a chapter on Histology, followed by one on general Embryology and terminates with a consideration of Surface Anatomy and Surface Markings. The Applied Anatomy is given at the end of the different subdivisions, while the embryology of special structures is distributed through the text.

Some of the older illustrations are replaced by newer ones. There are 99 figures less than in the American Edition. Illustrations of transverse sections of the extremities are conspicuous for their absence. Figures 489, 528, and 529 very meagerly testify to the invaluableness of accurate illustrations of transverse sections of the extremities. Such figures should have replaced the suppressed illustrations of circles with the names printed on four sides, used in the preceding editions to show the relation of the larger blood vessels to the surrounding structures. Space compensation could have been obtained by curtailing the text. Descriptions cannot be compared to illustrations for building up mental pictures.

In the American Edition there is a marked increase in the number of illustrations of sections of the brain stem; in the English Edition there is not. Schematic diagrams adequately show the course of the nerve tracts and position of the central nuclei.

It is the usual thing to see students,—when at work on the structure of the brain-stem—have as many as six text-books spread out before them. It requires a varying number to give the adequate information for reading serial sections that have

been stained by the Weigert-Pal method. Spalteholz's Atlas, Barker's Nervous System and a text-book on Histology, as Ferguson's are among the most useful. To be sure, it is excellent practice for a student to be forced to compare and correlate the subject matter as presented in a number of works; but then, have all students the means, opportunity and facilities for access to such an array of literature? By no means! It is the consensus of opinion among those who do study the subject that some one Anatomy should be adequate as a guide to what is wanted. An increased number of illustrations means increased expense. This can be kept down to a certain extent by curtailing the text, as before stated. Prof. Mall in commenting on an earlier American Edition of Gray, said: "More than 16 pages are devoted to the surface markings of the cerebrum, which could have been largely shown with illustrations without any text; while the internal structure of the medulla receives but 6 pages. The pons, medulla, and cord all suffer for want of good illustrations showing cross-sections." A text-book to have the greatest sphere of usefulness should be written to supply the needs of the student who works on his own initiative and the practicing physician who must from necessity possess a limited library. If it is purely for some advanced and limited purpose, it should be so stated in the title.

The chapter on cortical localization of function has been abbreviated, but compensation is manifest in the improved figures of the cerebral hemispheres (figs. 761 and 762). Figures 611 and 614, the arrangement of figures 1029, 1030, 1031, and 1032 are revelations of the improved methods.

The characteristic clearness of the text and general character of the previous editions are retained, but breathing an incipient transformation along modern methods. It was a retrogression to drop the diagrams showing the relation of vessels by the use of circles and names printed on the four sides, without offering something better; it was inertia not to have added new and accurate figures of transverse sections of the brain-stem; it was advancement in giving the BNA in English first place.

The author and publishers are to be congratulated on the excellent character of this edition. If the reviewer was asked which edition he preferred, his answer would be—the American edition for the treatment of the Nervous System; the English edition for the BNA. Otherwise there is no material difference.

F. E. B.

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I hereby agree to treat medically and/or surgically, in accordance with the above schedule, any injured person who is sent to me, and for whose treatment any Insurance Company, a member of The Casualty Underwriters' Association of California, is responsible or interested, and I agree not to incur any further expense without the consent of the Insuring Company.

..... Surgeon.

..... Street and Number.

..... City or Town.

..... Witness.

Dated at....., this..... day of....., 191..

### REPORT TUBERCULOSIS.

In public health activities the methods and spirit of the Tuberculosis Campaign are coming to be accepted throughout the United States. Tuberculosis being a disease in which prophylaxis is at present more effective than cure, and being one in which the infecting agent is known a system of prevention is being developed which can be applied to its control.

Of this system no one feature is more important than the registration of cases with a central bureau. In order to deal successfully with any disease one should know the extent and manner of its distribution.

With this fact in view a special effort is being made by the Board of Health of this State to obtain the name and address of every case of tuberculosis, as provided by the law of 1906, and a special bureau has been created by the Legislature with this for its first object.

It is the experience in all communities where this law has been effective that apparent objections have faded away in the light of experience.

Cases must be reported in writing to the local health officers who forward the list, together with that of other communicable diseases, to this office at the end of each week. The patient is not informed of the notification and in cases reported by physicians it is not the policy of the bureau to deal with patients except through or as requested by the physicians themselves.

Yours very truly,

BURT F. HOWARD,  
Director, Bureau of Tuberculosis.

### TRAINING IN HOME ECONOMICS.

The constantly increasing interest in the problem of right living demands trained workers in many fields. The State Normal School of Manual Arts and Home Economics at Santa Barbara, California, is offering courses in the many phases of Home Economics to fit interested students to meet the needs of the State, the community and the individual.

Courses have been offered since the establishment of the school by the Legislature of 1909 in the subjects required for Grade and High School Special Certification in Home Economics, with high entrance requirements, applying strictly to modern school regulations.

(The entrance requirements are as follows: Graduation from a college, university, normal or special school; or certificate of attendance for two or more years in such schools, with recommendations from the same; or successful teaching experience.)

The success of the graduates, evidencing the thoroughness of the training in all subjects, the school has broadened its scope to include some of the newer aspects of Home Economics for professional nurses, and for those women of maturity who would become directors of institutions through their knowledge and practice of Institutional Management.

The course most interesting to readers of this journal will be known as the "Nurse's Course in Home Economics," open at present to "registered nurses" who will be required to file the recommendation or credits from the Hospital from which they graduated, and a certification of their State registration, with any personal letters of recommendation which may be required.

The studies this first year will be adapted to the needs of the students as individuals, and as representing the demands made by the Hospital training classes over which the graduates of this course will preside as teachers and dietitians.

There will be no printed outlines for distribution

until the courses have been tried and standardized, but the character and reputation of the school is sufficient guaranty that the applicant will not only find her specific need, but will gain a broad comprehension of her subject.

Practical practice teaching in the hospitals will be required. Students will wear their uniforms in the Domestic Science and Dietetics laboratory.

A registration or diploma fee of two dollars is required. The duration of the course will not be less than forty weeks—divided into terms of ten weeks each—with intermissions of one or two weeks as arranged later.

There is no tuition. The fees will not exceed fifty dollars for the forty weeks. Twenty dollars, with the registration fee of two dollars, will be paid on entering. The balance will be paid at the close of fifteen weeks.

The school buildings, just completed, representing an investment of more than \$200,000, are built on one of the most beautiful sites in California and offer the most remarkable student life in the charming cloisters built round the spacious court from which one looks out on the restful blue of the Pacific Ocean.

There are no dormitories, but there are delightful apartments and bungalows conveniently located. The school maintains a dining hall or "Cafeteria" (conducted by the Institutional Management students and the entire group of Home Economic students, including those in the "Nurse's Course") where a noon meal will be served at cost.

Accommodations can be secured after arrival, and the cost per month need not exceed thirty dollars and may be much less.

The enrollment will be limited this semester to twenty students who will be selected on their applications and credentials.

The course will open February the sixteenth, registration day will be February the fourteenth or earlier. Registration closes February the twenty-eighth unless there are vacancies; when additional students will be received on promise to make up all the preceding work.

Students will be permitted to do a maximum of work in a minimum of time, therefore all must be physically fit to meet the obligations of their interesting studies and must send with their application a registered physician's certificate of good health.

All the school activities, entertainments and lectures are open to the nurses as is the well-selected school library and the city's public library. Santa Barbara offers a delightful climate and many delightful advantages.

Those desiring to enter should send for application blanks as soon as possible, stating name of Hospital diploma and years of experience in a Hospital or as private nurse, and notice of acceptance will be sent promptly on receipt of full information as to the applicant's qualifications.

The committee from the State Nurses' Association have visited the school and are familiar with the general scheme of the course.

Address all correspondence to Miss Ednah A. Rich, President, State Normal School of Manual Arts and Home Economics, Santa Barbara, California.

### BOUILLON CUBES NOT CONCENTRATED MEAT ESSENCE.

The belief of many people that bouillon cubes are concentrated meat essence and of high nutritive value, has been shattered by a recently issued bulletin of the Department of Agriculture which says, that while they are valuable stimulants or flavoring agents they have little or no real food



value and are relatively expensive in comparison with home-made broths and soups. This bulletin (No. 27) compares the contents and food value of bouillon cubes with meat extracts and home-made preparations of meat.

The ordinary commercial bouillon cubes, according to this bulletin, consist of from  $\frac{1}{2}$  to  $\frac{3}{4}$  table salt. As they range in price from 10 to 20 cents an ounce, purchasers of these cubes are buying salt at a high price. The cubes do contain a small amount of protein (muscle-building material) in addition to their stimulating properties, and the makers of most of the cubes make no advertised claim that they are concentrated beef broth or essence. However, many housewives believe that they are and that they possess high nutritive value, especially for invalids. This is not the case. The fact that the cubes sell for from 1 to 2 cents each, and each cube makes a cup of broth, misleads the housewife into believing that she is securing meat extract cheaply when really she is buying it in an expensive form.

According to analyses of these cubes, besides the common salt which constitutes from 49 to 72% of the total weight, the amount of meat extract ranges from 8% in the poorest brands to but 28% in the very best. The third important ingredient is plant or vegetable extract which constitutes from 3 to 30%. This plant extract is useful because of its flavoring properties but has slight, if any, nutritive value.

### INTERESTING FRAUDS.

**Deafness-Cure Frauds.**—The name of the deafness-cure quack is legion. Some carry an alleged cure for deafness as a "side-line," some sell on the mail-order plan their worthless "course of treatment," while still others, and these probably are in the majority, dispose of, at an exorbitant price, devices that are trivial, worthless and often dangerous. The following are some "deafness-cure" concerns: Dr. L. C. Grains Company (formerly Dr. Guy Clifford Powell), Chicago; Dr. Edward E. Gardner, New York City; George P. Way, Detroit, Michigan, and George H. Wilson, Louisville, Ky. (Jour. A. M. A., Nov. 1, 1913, p. 1645).

**The Friedmann Cure.**—After studying the cases inoculated by Dr. Friedmann at Montreal, Ottawa, Toronto and London, Ontario, a committee of the Canadian Association for the Prevention of Tuberculosis has reported unfavorably on the treatment (Jour. A. M. A., Nov. 1, 1913, p. 1648).

**Trypsogen.**—Besides exploiting a clay poultice, "Antithermoline," the G. W. Carnrick Company appears to be chiefly concerned in the promotion of "internal secretion" specialties. Thus it markets the diabetes remedy, "Trypsogen" tablets, said to contain "the enzyme of the islands of Langerhans with the tryptic and amylolytic ferments of the pancreas" along with gold bromid and arsenic bromid; Secretogen Elixir, said to be "prepared from gastric secretin obtained from the pyloric antrum and pancreatic secretin from the duodenum, combined with the enzymes of the peptic glands, and one-twentieth of one per cent. HCl"; Secretogen Tablets, said to be "prepared from prosecretin and succus entericus obtained from the epithelial cells of the duodenum, combined with pancreatic extract"; Kinazyme, "a preparation of extract of spleen, reinforced with trypsin, amylopsin and calcium lactate." While great claims have been made for Trypsogen and while it has been most widely advertised it is the opinion of the most eminent students of the question that pancreas is not efficacious in diabetes. Trypsogen should be con-

sidered as an unscientific shot-gun mixture. When the Council on Pharmacy and Chemistry paid less attention to the therapeutic worth of a proprietary preparation, both Antithermoline and Trypsogen were admitted to New and Nonofficial Remedies. They were dropped some years ago, when the Council revised its rules (Jour. A. M. A., Nov. 1, 1913, p. 1649).

**Radio-Active Waters.**—All naturally occurring waters, even rain water, are somewhat radio-active. While the waters of Hot Springs, Ark., have been investigated by the Department of the Interior, this information has been suppressed "for administrative reasons." It is stated only that the waters are "radio-active to a marked degree," a statement which might have emanated from a patent medicine manufacturer (Jour. A. M. A., Nov. 1, 1913, p. 1649).

**"Therapeutic" Names.**—Claiming that physicians demand that they be supplied with "a pill for every ill" most pharmaceutical houses supply "Pills Gonorrhea," "Pills Spermatorrhea," "Pills Leukorrhea," "Pills Dysmenorrhea," etc. Therapeutically suggestive names for medicines lead to thoughtless use by physicians and to counter-prescribing by druggists. That the use of therapeutic titles is not an economic necessity is illustrated by the fact that E. R. Squibb & Sons are discarding such titles (Jour. A. M. A., Nov. 1, 1913, p. 1650).

**Mouth Washes.**—Recent investigations seem to show that adherence of mucin caused decay of the teeth. So-called antiseptic mouth washes and alkaline washes do not remove this mucin and therefore do not prevent decay of the teeth. The vegetable acids, such as fruit juices and diluted vinegar, are the most successful agents for the removal of mucin (Jour. A. M. A., Nov. 8, 1913, p. 1718).

**Pennyroyal, Tansy and other "Emmenagogue Oils."**—An examination of the oils of Pennyroyal, tansy, savin, rue, thyme, turpentine and of apiol proves that they have no specific or directly stimulating action whatever on the uterine muscles; on the contrary they prohibit the contraction of the uterus and even paralyze it. If these oils exhibit any emmenagogue or abortifacient action whatever, it is due to a general constitutional poisoning or gastro-intestinal irritation and not to any specific action in accord with the intent for which they are sometimes administered (Jour. A. M. A., Nov. 8, 1913, p. 1725).

**Mouth Washes.**—Such polypharmacy as is represented by the complex solutions, official and proprietary, used as mouth washes is nonsense. In them the value of useful ingredients is obscured by the useless shrubbery which surround them. A dash of this and a dash of that in these mouth washes or gargles is simply playing to the galleries (Jour. A. M. A., Nov. 15, 1913, p. 1812).

**The action of Atophan.**—It has been recognized that the administration of Atophan increased the elimination of uric acid and that there was a possibility that a greater production of uric acid is induced by the drug—a result which would scarcely encourage its use in therapy. Recent investigations, however, favor the view that the drug merely stimulates the kidneys to abstract from the blood a greater quantity of the purin end-product than it normally would (Jour. A. M. A., Nov. 15, 1913, p. 1818).

**Baughn's Pellagra Remedy.**—A booklet issued for Baughn's Pellagra Remedy, American Compounding Co., Jasper, Alabama, suggests symptoms of all kinds as an indication of pellagra. If you have any of these, the inference is that the "grim specter," pellagra, has you in its grasp! Horror

is piled on horror in the most approved "patent medicine" style, reaching as a grand climax a description of "the last stages" and closing with the peroration: "And the last stage, till now—the MAD HOUSE and DEATH." As the exploitation of this nostrum interfered with the attempts of health officers to eradicate pellagra in Alabama, it was analyzed in the A. M. A. Chemical Laboratory. The nostrum comes in two forms, capsules and a powder for external use. The capsules were found to contain charcoal, basic iron sulphate and a little quinine. The powder was composed of common salt and basic iron sulphate (Jour. A. M. A., Nov. 15, 1913, p. 1828).

**Regulin.**—Regulin is agar-agar (N. N. R., 1913, p. 20) to which some cascara preparation has been added. The product at one time was described in the Appendix to New and Nonofficial Remedies as follows: A mixture of agar-agar in a dry form with extract of cascara sagrada representing 15 per cent. of an aqueous fluid extract of cascara sagrada (Jour. A. M. A., Nov. 15, 1913, p. 1832).

**Waterbury's Compound.**—Waterbury's Compound—called Waterbury's Metabolized Cod-Liver Oil Compound until the A. M. A. Chemical Laboratory showed it contained practically no cod-liver oil—was one of the proprietary preparations advertised both in "display" form and also in the form of an "original article," in the Army and Navy Medical Record—a fraudulent publication that offered its editorial pages for sale. Physicians are now receiving from the Waterbury Chemical Company, a reprint of what purports to be an editorial from the Army and Navy Medical Record, entitled "One of America's Most Valuable Preparations." The preparation, of course, is "Waterbury's Compound" (Jour. A. M. A., Nov. 15, 1913, p. 1830).

**Sensitized Virus-Vaccine.**—Besredka asserts that the injection of living germs sensitized in certain ways produces a more substantial immunity and greater production of antibodies than the injection of germs killed by heat or in other ways. In apes sensitized typhoid bacilli gave absolute protection, causing no fever and no reaction, while killed bacilli failed to protect adequately. As a result of these experiments a number of "sensitized virus-vaccines" have been prepared and the antirabic vaccine used in France is now a sensitized virus. Before the employment of the sensitized typhoid virus-vaccine can be considered, much evidence must be produced that there is no danger of producing typhoid carriers and that this vaccine gives any better protection than the vaccines now in use. Similar objections hold against other vaccines of this kind and at present the obstacle to the use of such living germs for protective purposes would seem to be quite impassable (Jour. A. M. A., Nov. 15, 1913, p. 1814).

**Berledets.**—This is an anti-fat remedy sold under the claim that dieting and exercise are unnecessary, but the directions for which recommends moderation in diet and free exercise. Examination in the A. M. A. Chemical Laboratory showed the nostrum to consist of tablets, each containing about 9 grains boric acid, along with corn starch and milk sugar. It is evident that Berledets will cure obesity only by seriously interfering with digestion (Jour. A. M. A., Nov. 22, 1913, p. 1917).

**The Morley Ear-Phone.**—The Morley Invisible Ear-Phone, Morley Company, Philadelphia, Pa., is nothing more or less than the old, well-known Toynbee artificial drum-head. It consists of a circular piece of oiled silk about one-quarter inch in diameter, through the center of which a piece of silk thread has been passed, for the purpose of holding the oiled silk in position. A small piece of flexible tubing comes with it to aid in inserting

the device in the ear. The indiscriminate sale of a device of this sort, especially at exorbitant prices and under fraudulent claims, is not merely an injury to the purse, but a distinct menace to the health of the deaf (Jour. A. M. A., Nov. 22, 1913, p. 1919).

**Veroform Germicide Omitted from N. N. R.**—Veroform Germicide is described in New and Nonofficial Remedies, 1913. It is a formaldehyde soap solution, containing 20 per cent. of formaldehyde. The report of the U. S. Public Health Service on commercial disinfectants having shown Veroform Germicide to have a phenol co-efficient of but 0.43, the manufacturers of the preparation were asked to present evidence to justify the term "germicide" in the name and the claim that it has more bactericidal effect than phenol. As the Veroform Co. produced no evidence to substantiate the questioned claims, the Council of Pharmacy and Chemistry voted to omit the preparation from New and Nonofficial Remedies (Jour. A. M. A., Nov. 22, 1913, p. 1920).

**Pulmonol.**—Pulmonol is a consumption "cure" put out by the Pulmonol Chemical Co., New York. As always in the case of consumption "cures," the testimonials issued may be divided into two classes, those who really had tuberculosis and those who did not have it. Investigation of some of the testimonials given some time ago, generally show that those who relied on the nostrum are dead while those who got well never had tuberculosis. Examination in the A. M. A. Chemical Laboratory indicated that each fluid ounce of Pulmonol was approximately equivalent to 29 gr. of potassium guaiacol sulphate, 10 gr. of sodium benzoate and 1-24 gr. of strychnine sulphate (Jour. A. M. A., Nov. 29, 1913, p. 1998).

#### ERRATA.

On page 32 of the January issue the sentence beginning with "The next was botanies," should read "The next word was botanies." The sentence beginning with the "Greek Touy" should read the "Greek töme." The sentence beginning with "Sume a word" should read "such a word." The sentence beginning with "wee-kis-im" should be spelled "kiss-im."

#### NEW MEMBERS.

Bohm, Jno. E., San Francisco.  
Ruggles, Howard E., San Francisco.  
Slemons, J. M., San Francisco.  
Walton-Dorn, Dora I., San Francisco.  
Walton, G. E., Oakland.  
Meads, A. M., Oakland.  
Campbell, W. H., Oakland.  
McCracken, Wm. B., Berkeley.

#### RESIGNED.

Fowler, W. S., Bakersfield, Cal.  
Hirschler, D. Lee, Norfolk, Va.

#### DEATHS.

Ulliyot, Thos. Henry, Monrovia, Cal.  
Miller, C. C., Boulder Creek, Cal.  
McDonald, J. A. J., San Francisco.  
Ward, W. H., died in Long Beach, Cal.  
Thurston, Wm., died in Orland, Cal.  
Godfrey, E. L. B., Pasadena, Cal.  
Sawyer, A. F., died in address unknown (formerly San Diego).  
Wilhelm, August, San Francisco.  
King, E. W., San Francisco.  
Stearns, Wm. H., Los Angeles.